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ABSTRACT

A manual is presented to help incorporate team development into training programs for nurse practitioners, physician assistants, and primary care physicians. It is also directed to practitioners who wish to improve teamwork and is designed to improve the utilization of the nurse practitioners and physician assistants. A group of one or more mid-level practitioners and one or more physicians is referred to as a team. Team development includes improving the coordination of team activities, decision-making, utilization of team members' skills, problem solving, and conflict negotiation. The development of a team depends on many factors, including the commitment of the organization or institution to the concept and the commitment and the personalities of the individuals on the team. The process of team development includes knowledge of team concepts and development methods, small group process, problem-solving experience, and joint clinical practice. Five modules are presented: health care team development (concepts, issues, and influences); roles and barriers to team development; team building skills; team practice organization; and health care team maintenance. Each module contains exercises and readings that help team members examine their attitudes about areas of team practice. Bibliographies identify longer resource documents, and the exercises focus on skills to improve team practice and patient care. (SW)

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TEAM DEVELOPMENT MANUAL

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TEAM DEVELOPMENT MANUAL

by

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September 1982

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Introduction

This manual was developed by the Nurse Practitioner/Physician Assistant Statewide Advisory Committee of the California Area Health Education Center System to assist nurse practitioner, physician assistant and primary care physician programs in teaching team development to their students. The manual can also be utilized by nurse practitioners, physician assistants, and primary care physicians in practice who wish to improve their work together as a team.

Team development is the learning and application of ways to manage interdependence in order to get the job done in the best possible way.[1] It includes improving the coordination of team activities, decision making, utilization of team member's skills, problem solving, and conflict negotiation.

The development of a team depends on many factors, including the commitment of the organization or institution to the concept and the commitment and the personalities of the individuals on the team.

The process of team development includes knowledge of team concepts and development methods, small group process and problem solving experience, and joint clinical practice.[2]

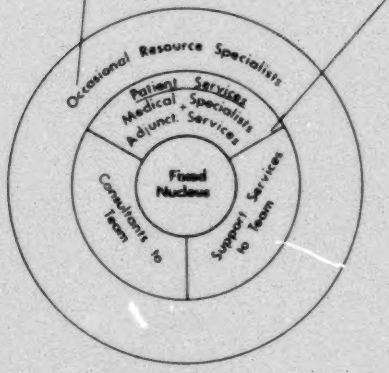
The delivery of health care has changed in our present society from the solo physician who did everything, including care for patients in his own hospital, to a very complex highly technological organization of care which includes services from new categories of health professionals. The primary care health care team can include many people, for example, secretaries, receptionists, nurses, nutritionists, pharmacists, psychologists, social workers, physicians, nurse practitioners, and physician assistants. The extent to which these staff are part of the nucleus of the primary care team will vary by practice setting. Figure 1 identifies the many individuals or professsionals that could be involved in an extended primary health care team. In educational settings, students also become a part of the team during their clinical training.

Figure 1

The Primary Health Care Team

OUTER LAYER

Members are only used occasionally but when needed, may become important members of the team



Team Structure

MIDDLE LAYER

Members may be used frequently and under certain conditions may be included as part of the nucleus.

1. MEDICAL SPECIALTIES USED BY PATIENT
   - Obstetrician
   - Orthopedist
   - Opthalmologist
   - Surgeon
   - Dermatologist
   - Mental Health Worker
   - etc

   PARAMEDICAL AND ADJUNCTIVE SERVICES USED BY PATIENT
   - Pharmacist
   - Physical Therapist
   - Homemaker
   - Visiting Nurse
   - Social Worker
   - Legal Specialist
2. SUPPORT TO TEAM SERVICES
   - Clinic Nurses
   - Medical Aides
   - Receptionists
   - Secretaries
   - Record Librarians
3. CONSULTANTS TO TEAM
   - Medical Specialists
   - Legal Specialist
   - Anthropologist
   - Social Worker
   - Nutritionist
   - Mental Health Specialist

Often nurse practitioners, physician assistants, office staff, nurses, and physicians form the nucleus of the primary care health care team. In practice, the nurse practitioner, physician assistant, and physician function interdependently. Unfortunately, just being together does not create a team or a collaborative practice, one with the potential to offer the patient and the patient's family more comprehensive, better coordinated, more effective service. A successful team must work together to perfect what it does and how it does it (team development).

Because this manual is intended to improve the utilization of the nurse practitioners and physician assistants, the focus of the readings and exercises is on the development of the NP/PA-MD team; the relationship of these providers, of course, both affects and is affected by the potential and the function of the greater team. Inclusion of additional members on the team in the process of team development will enhance the potential for coordinated, effective, comprehensive services for the patient.

Parker, Alberta W.: The Team Approach to Primary Health Care, University of California, Berkeley, 1972, Figure 1, p. 16. Reprinted with permission.

The purpose of developing the NP/PA-MD team is to provide better patient care by improving utilization of all the skills of the team members. Team concepts and the team approach may involve changes in attitude and behavior.[3] This team development manual is based on the belief that both knowledge and process are needed to change behavior.

The manual consists of five modules: Team Health Care Development: Concepts, Issues and Influences; Roles and Barriers to Team Development; Team Building Skills; Team Practice Organization; and Health Care Team Maintenance. The modules are intended to help the team deal with the issues of team concept, influences on the team, the nurse practitioner's, physician assistant's, and physician's roles and role conflicts, team office organization, and the development of basic skills to improve teamwork

Each module is organized into sections containing readings and exercises. The short readings included help the team gain information and examine their attitudes about areas of team practice. The bibliography identifies longer resource documents or books that develop the ideas and issues presented in the readings. The exercises are designed to help the team develop skills to improve their team practice and thus their patient care.

The needs of the educational or practice setting and the configuration or membership of the team will determine how the manual is used. If the emphasis is only upon the NP-PA/MD team members, and the faculty or team members choose to progress through the manual systematically, the total number of hours would be at least 30 hours.

Some faculty or practicing teams may choose to select or delete exercises depending upon their own needs and experiences. Many exercises may need to be adapted so that members of the team other than the NP, PA and MD can participate actively in team development sessions. Although it is beyond the scope of this manual to provide lists of alternative exercises, the Team Development Curriculum, also developed by the Statewide NP/PA Advisory Committee to the California AHEC, can help faculty locate additional sources.

This manual is focused almost exclusively on readings and exercises relevant to NP/PA and MD team members and on team development in a practice setting. This orientation sets up some constraints that users of the manual need to acknowledge and plan to overcome.

The first constraint is essentially one of group size. If only an MD and an NP or PA participate in group sessions, that is, if the group is comprised of only 2 or 3 people, problem-solving and conflict resolution may be more difficult, since it is harder to de-personalize issues in very small groups. Three resolutions to this problem come to mind:

1) Nurses, support staff, and other health professions can be involved whenever possible. This will serve to strengthen the whole team's development and it will also provide a larger forum for the discussion and resolution of conflicts.

2) A consultant, faculty member, or individual skilled in group process could participate in team development activities. This individual could help the team maintain a positive problem-solving environment and focus.

3) If consultants are not available, developing teams could benefit from exposure to faculty or community MD-NP/PA team role models. These individuals will have both knowledge and first hand experience to share. Their presence will enlarge the group and they may raise issues or concerns that a smaller, more intimate group would find more difficult to confront.

The second constraint is that many of the exercises are oriented to team development and role negotiation in real-world practice settings rather than in an educational setting because this is where the teams are being prepared to practice. However, this means that educators may need to adapt some exercises for students. In some cases a student may lack the information needed to complete an exercise, so he or she might be assigned to observe or interview a role model in practice to complete the exercise. Some of the exercises direct the team to evaluate their practice or practice setting and institute needed changes. Students may not be in a position to institute change but are certainly in a position to evaluate and give feedback which can be used by faculty to institute change.

While acknowledging the focus and the constraints of the manual, it is important for the user to recognize that it is not the intent of the manual to exclude other team members or to promote one category of health care worker. Faculty and NP/PA-MD team members need to be constantly aware that the purpose of all health care team development is to improve the care available to the client by providing the best service possible, given by the appropriate person on the team at the appropriate place, coordinated in such a way as to provide for the health needs of the whole client and his family and to prevent fragmentation, frustration, confusion and increased costs to the client.[4]

---

[1] Rubin, I.; Plovnick, M.; Fry, R.: Improving the Coordination of Care: A Program for Health Team Development, Ballinger Publishing Co., 1975, Cambridge, p. 7.

[2] Smith, G.H.; Anderson, J.; Carnevali, D.; Truelore, E.; Urban, N.: "An Integrated Approach to Interdisciplinary Health Team Education," in: Interdisciplinary Health Care Teams in Teaching and Practice, Eds. De Witt C. Baldwin, Jr., Beverly Davies Rowley, and Virginia H. Williams, New Health Perspectives, Inc. and School of Medicine, University of Nevada, Reno, 1980, pp. 84-97.

[3] Baldwin, De Witt C., Jr.; Baldwin, Michele A.: "Education for Team Work in Primary Health Care," in: Approaches to Teaching Primary Health Care, Eds. Harry J. Knopke and Nancy L. Dickelman, C.V. Mosby Co., St. Louis, 1981, p. 184.

[4] Parker, Alberta W.: The Team Approach to Primary Health Care, University Extension, University of California, Berkeley, 1972, pp. 4-8.

MODULE I

Health Care Team Development:

Concepts, Issues and Influences

Health Care Team Development: Concepts, Issues and Influences

Advanced technology, proliferation of medical and health care knowledge and skills,and increased demands from the public for different types of services and for quality of care lead to medical specialization. Specialization, however, often results in fragmented care for the patient. One person alone is no longer capable of possessing all the knowledge and skills or of being available in all the various settings to provide care to the sick, prevent illness, and promote wellness.[1]

This fact and the many changes within society and within the health care system itself -- for example, the growth of primary care, family practice, group practice, use of technology, the consumer movement, minority and women's rights groups -- have promoted the development of various kinds of teams which provide a variety of services within the health care system. Teamwork permits health care providers to pool and coordinate their resources. The client and his or her family benefit from the team approach by gaining access to improved, less fragmented care.[2]

The NP/PA-MD team is an example of a client- and service-oriented team. This type of team is organized to solve the individual patient's health care problem and to deliver a group of health care services.[3]

All health care teams must define the tasks, objectives, roles, and functions of their members. Client-centered, service-oriented teams have been found to have less clarity of purpose, role, function, and management structure than more technologically oriented teams, such as crisis teams.[3] These factors make team development for the NP/PA-MD team more difficult, so working on developing a team becomes a challenging and critical task. In addition, physicians, nurse practitioners, and physician assistants each also have their own expectations, personalities, and motivations which influence their involvement in the development of the team.

Effective team development requires that nurse practitioners, physician assistants, and physicians understand what a team is and what it means to work as a team. They need to confront the individual, organizational, and community influences that impede their efforts to coordinate their roles to provide improved patient care.

This module contains two sections: 1) team concepts, and 2) issues and influences on team development. Each section includes readings, bibliogrpahy and exercises.

As a measure of participant expectations before team development begins, each participant should complete the Health Care Team Survey.

OBJECTIVES

Participants will identify

- their concepts of and feelings about team practice,
- their present practice styles,
- who is involved in their patients' care,
- problems and potentials of team practice, and
- the role of the patient within the team.

Participants will recognize the positive and negative forces for team development in their situations.

Participants will begin to formulate plans to influence the forces for team development in their situations.

SECTION A: HEALTH CARE TEAM CONCEPT

Overview:

This section contains four readings, an assessment tool called the "Health Care Team Survey," and two exercises. Remember, the survey is most meaningful if completed before any reading is started and prior to any group sessions. The readings and bibliography are intended to be read by the participants prior to the team's group sessions. If all the exercises are completed, the group sessions will take about three hours.

Readings:

1. "Changes Which Promote Team Delivery of Health Care"
2. "Potentials and Problems in Team Practice"
3. "The Patient's Bill of Rights"
4. "Team Definitions and Characteristics"

Bibliography:

Brill, Namoi Isgrig: Teamwork: Working Together in the Human Services, J.P. Lippincott Co., Philadelphia, 1976, Ch. 2.

De Witt, C. Baldwin, Jr.; Baldwin, Michele, A.: "Education for Teamwork in Primary Care," Ed. Harry J. Knope and Nancy L. Dickelman, in: Approaches to Teaching Primary Health Care, C.V. Mosby Co., St. Louis, 1981, pp. 176-181.

Ducanis, Alex J.; Golin, Anne K.: The Interdisciplinary Health Care Team, Aspen System Corp., Germantown (Maryland), 1977, Ch. 1.

Exercises:

Exercise 1: The Health Team Survey.

Exercise 2: Are we a team? Do we want to be a team?

If the faculty or team wishes to choose only one of the exercises in Section A, completing Excercise 1: "The Health Team Survey" is recommended by the author.

Reading

Recent changes within society and within the delivery of health care have promoted the development of various types of teams within the health care system. The same changes that create the need for teams often also create problems that keep teams from operating as effectively and efficiently as they might. Discussing these changes will help the team identify the new challenges that face them and approach with a positive perspective. The team can discuss Micro and Ross's "Changes Which Promote Team Delivery of Health Care" to complete Exercise 1.

CHANGES WHICH PROMOTE TEAM DELIVERY OF HEALTH CARE

Changes	Mode of Change
Changes in the care of patients	from fragmented delivery of separate categorical services by separate workers to comprehensive primary health care.
Changes in the model of medical practice	from solo or independent arrangements to group practice and ambulatory clinic arrangements.
Changes in the focal points of delivery of community health	from centralized clinics and out patient departments to decentralized, neighborhood-based ambulatory health centers.
Changes in the complexities of health problem solving	from specific disease-orientation to the inter-relationships of disease with poverty, poor housing, low social-economic educational stature and race.
Changes in the social relevance of health care organizations	from insensitivity to enlightenment around issues of racism, minority rights, women's liberation, meaningful work and consumer participation.
Changes in the needs and demands for and availability of health care personnel	from the less available, more highly-trained and skilled ones to the more available, less specialized ones.

CHANGES WHICH PROMOTE TEAM DELIVERY OF HEALTH CARE

Changes	Mode of Change
Changes in the self-and-other role perception of doctors	from high-status elitists to perceptions more closely approaching peer-level relationships with non-doctors.
Changes in the academic preparation of health and medical workers	from a career direction in a more-or-less autonomous role to a career direction in a more-or-less team setting.
Changes in the measurement of success	from the early days when the various communicable disease control strategies produced significant reductions of disease to the present day complexities of interrelated chronic and habituating diseases.
Changes in national programs for reorganizing the delivery of health services	from conventional, categorical medical models to those requiring interdisciplinary team arrangements and other innovative strategies.
Changes in the financing of medical services	from fees for medical and physician service to fees for health care services, particularly by third party insurance payers.
Changes in management theory and practice	from Theory-X to Theory-Y; from autocratic hierarchical styles of leadership to more democratic, participatory styles.
Changes in the basic responses to human needs and work situations	from subjugation to self-determination and self-esteem.
Changes in regard to the needs of consumers and patients	from passive recipients to active participants in treatment and planning processes.

Micro, Paul R.; Ross, Helen S.: Health Education and Behavioral Science, Oakland, Third Party Assoc., Inc., 1975; adaptation by Beverly Davies Rowley, ABD, University of Nevada School of Medicine, Reno. Reprinted with permission.

Working together in a team has its risks and its benefits. Some of the problems and potentials of team practice are identified here for the team. The potentials are cited to give the team direction and inspiration as they work to become a team. At the same time, recognizing the commonality of certain problems teams encounter in attempting to work together can depersonalize problems and help the team seek solutions from others who have faced similar situations. The potentials and problems are debatable issues. They can be discussed as part of Exercise 1.

POTENTIALS AND PROBLEMS IN TEAM PRACTICE$^{4-6}$

Potentials

Team practice can:

- increase the effective use of specialized knowledge and specialists;
- provide a more comprehensive and integrated range of service, thus decreasing duplication and fragmentation;
- provide an experience of satisfying participatory learning and personal growth for team members;
- ensure the delivery of the appropriate service at the best site by the most appropriate person;
- make comprehensive services less costly by increasing the rationality of task assignments;
- permit the patient to be a more active participant in planning and executing his or her health care;
- help the patient more easily identify those who have continuing responsibility for his or her care;
- promote identification of and planning for the patient's or situation's total problems rather than just for the segment of the problem one provider specializes in or can see;

- provide a forum for examination and evaluation of ideas from the differing frames of reference of the various members;
- decrease competition between team members as each member's expertise is given recognition;
- be supportive, as self-revelation and communication lead to more understanding of each team member's position, expectations and responsibilities;
- create the time for meetings where areas of tension can be dealt with and creative solutions to situations can be found rather than fostering a continued disregard for differences and problems.

Problems

Team practice can:

- take on the sometimes cumbersome and slow-moving characteristics of participatory democracy;
- foster undesirable competition between members;
- accentuate the difference in status and financial renumeration among team members;
- demand commitment to teamwork from workers on all levels within the health care system who may not only be uncommitted to the concept but also poorly equipped to function in this manner;
- decrease direct patient participation for team members as they become consultants rather than direct providers in certain situations; for example, the physician may not see all the patients the nurse practitioner or physician assistant sees but may consult or sign prescriptions without ever seeing them;
- seem to lead to greater rather than less fragmentation of service;

- be frightening to the individual members as participating on a team necessitates self-revelation and the need to communicate with others;

- expose the tensions that exist between various disciplines and the lack of clear definitions of boundaries of knowledge and expertise, often making teamwork extremely difficult;

- accentuate problems of role definition and role overlap;

- create the need for meetings which may be time consuming and, if not well organized, frustrating, especially for those used to autonomous decision making;

- raise the questions of who should provide supervision for which area of practice; for example, the nurse practitioner practices under standardized procedures in the area of medical diagnosis and treatment, but as a nurse, he or she is responsible under the nursing license for nursing procedures which are not within the physician's realm of supervision;

- ask that team members enter into a group situation before they have had a chance to confront their own values and perceptions of how they should interact, creating a problem of communication;

- seem like a loss of uniqueness, creativity and autonomy to the individual as the necessity of sharing and collaborating may appear to submerge the individual into the group.

Adapted from Brill [4], Ducanis and Golin [5], and Parker [6].

The reason for team practice is to provide improved service to the patient and his or her family. Teams can relate to patients in a variety of ways. The relationships range from the traditional authoritarian relationship to one where the patients assume almost complete responsibility for their own health and care and utilize the health care team as consultants. The identification of the role of the patient and the family within the team practice is essential to the success of that service. The team must be aware of and take into account the patients' rights. Familiarity with the Patient's Bill of Rights will help facilitate this. In addition, if self-reliance and self-care are to be fostered, the team must allow and insist on the patient's participation in the team's planning and execution of his or her care. The team can incorporate the position and responsibility of the patient and his or her family on the team and the Patient's Bill of Rights into the discussion of their concept of team provided health care as part of Exercise 1: "The Health Care Team Survey."

A PATIENT'S BILL OF RIGHTS[7]

1. The patient has the right to considerate and respectful care.

2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know by name, the physician responsible for coordinating his care.

3. The patient has a right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include

but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person resonsible for the procedures and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequence of his action.

5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussions, consultation, examinations, and treatment are confidential and should be conducted discretely. Those not directly involved in his care must have the permission of the patient to be present.

6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.

7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services.

8. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has a right to refuse to participate in such research projects.

Physician-nurse practitioner/physician assistant teams mean different things to different people. Frustration and dissatisfaction often occur because the expectation about what the team practice should be varies among the individuals involved in the team. The reading, "Team Definitions and Characteristics of Teams," is intended to be used by the team in defining the type of practice they want to develop and in defining and evaluating their present practice. This can be done as a part of Exercise 2.

TEAM DEFINITIONS AND CHARACTERISTICS

Team Definitions

Team is the entire range of health professions and occupations now engaged in delivery of services, or a method of delivering comprehensive health services or an identified group of health providers who work closely together on a common task.[8]

A health care team is a group of health care workers organized to provide patient-client care and whose task requires interdependent functioning.[9]

An interdisciplinary team is a functioning unit composed of individuals with varied and specialized training who coordinate their activities to provide services to clients.[10]

Client-oriented team is a health care group organized around individual health care problem solving.[11]

Service-oriented team is a group organized around the delivery of a group of health care services.[11]

Intervention-oriented team is a group organized around the effort to reach certain specific populations-at-risk.[11]

Team practice is a process in which the knowledge and skills of various members are brought to bear on a clinical or nonclinical task.[12]

Parallel practice is a process where individuals utilize their knowledge and skills independently to work on separate tasks although there is some connection of the individuals within an organization. The patient sees one person as the provider, not the team. Traditionally, physicians in a group practice or health maintenance organization have parallel practices. When physicians, nurse practitioners and physician assistants practice in a parallel manner, the nurse practitioner and physician assistant often have little input into the practice. Consultation is usually from the physician to the nurse practitioner and physician assistant only and the model of health care is usually the traditional medical model - oriented toward the treatment of disease rather than to health maintenance or disease prevention.[12,13]

A supervisorial practice is one in which the physician presumes that the legalities which surround the practice of the nurse practitioner and the physician assistant require that he or she control the scope of the practice and activities. Since the realm that the physician is capable of supervising is medical care, this assumption results in a medical model type practice.[12,13]

A co-practice is one in which the team shares a common group of patients intentionally. Within the practice there is two-way consultation and shared decision making. Practitioners are colleagues whose actions are interdependent. Medical and legal realities are recognized but not utilized to inhibit joint decision making. The co-practice provides for the team to provide health care, not just medical care, and thus to promote the health care model.[12]

A collaborative practice is one in which the completion of the task requires the contribution of each person's unique skills and in which the individuals share values, responsibility and control.[14]

A joint practice is one in which nurses and physicians come together as colleagues in some sort of union to provide patient care.[15]

A NP/PA-MD team is a nurse practitioner and physician or a physician assistant and physician working together to provide health care to a group of patients in some fashion within a greater team. The team configuration reflects the medical and legal reality of the role: the individual's values, attitudes, professionalism, socialization, expertise, competence, philosophy of health care and previous clinical backgrounds.

Team Characteristics

A team...

- provides care to a common group of patients;
- develops goals for patient outcomes and works toward those goals;
- assigns appropriate roles and functions to each member and each member recognizes, accepts, and respects the role of the others;
- possesses a mechanism that enables all members to contribute and share information essential for effective patient care;
- creates mechanisms to ensure that patient care plans are implemented, services are coordinated, activities of the team are administrated, and performance is evaluated;
- is stable but flexible;
- requires that members function interdependently and collaboratively and are task-oriented.[16,17]

Adapted from Parker (16) and Brill (17).

Exercise 1: The Health Care Team Survey

Purpose

Each individual has his or her own beliefs and expectations about teams, team delivered care, and the roles of team members. The health care survey provides a method for the team members to identify and share some of their attitudes and concerns about team practice.

Time required: Approximately 2 hours.

Instructions:

1. Prior to the session the following occurs:

   - participants complete the Health Care Team Survey and give it to the facilitator
   - participants read: Brill: Teamwork: Working Together in the Human Services, Chapter 2; DeWitt and Baldwin: "Education for Teamwork in Primary Care" in Approaches to Teaching Primary Health Care; Ducanis and Golin: The Interdisciplinary Health Care Team, Chapter 1; "Changes that Promote Team Development", "Potentials and Problems in Team Practice," and the "Patient's Bill of Rights"
   - the survey results are tabulated by a secretary in a way that clarifies areas of agreement and disagreement
   - the facilitator reviews the survey results and areas of agreement or disagreement to clarify what needs to be discussed at the seminar.

2. At the session the facilitator shares the survey results with the team members and identities any areas of agreement and disagreement that he or she feels need discussion.

3. Additional items for discussion are identified by the participants from their concerns or from the reading materials.

4. The facilitator helps the team focus the discussion on identifying areas of disagreement that will need resolution if the team is to be able to work together. To accomplish this, the facilitator directs the team to examine the areas of disagreement to determine if there is real disagreement,

if the disagreement appears to be a major obstacle or one the team can tolerate; and if it is necessary and/or possible for the group to resolve the difference before significant team development can occur.

5. The team should record on the work sheet areas of agreement, areas of disagreement, and whether the areas of disagreement need resolution before the team will be able to function productively.

6. Areas of disagreement that need resolution need to be addressed in role negotiation, problem solving or conflict management sessions as the team learns these skills.

HEALTH CARE TEAM SURVEY

1. First, thinking of teams in general, please rank in order 1 to 5 those elements which you think are most important for a good team:

_____ Common goal
_____ Competence, skills
_____ Compatible personalities, rapport
_____ Mutual respect, trust
_____ Good communication
_____ Cooperation, ability to work together
_____ Openness, sharing, honesty
_____ Understanding each other's roles and disciplines
_____ Confronting issues, resolving conflicts, making decisions
_____ Enthusiasm, individual initiative

Now, for each of the following statements, please circle the letters which most closely represent your opinion:

SA Strongly agree
A Agree
D Disagree
SD Strongly disagree

Your initial response is important. Do not dwell on any one statement, but be sure to circle one answer for each.

The first group of statements relates to your opinions about teams in general:

2. The success of a team depends on its ability to communicate, no matter what its task. SA A D SD

3. Most people won't carry their share of the load when they know they have other team members who can do it for them. SA A D SD

4. The most important thing for a good team is that each team member brings unique professional skills. SA A D SD

5. I would rather have a leader make decisions and delegate responsibility than make decisions as a team. SA A D SD

6. A team can accomplish more than the same individuals could working separately. SA A D SD

7. A team should put up a united front for its public. SA A D SD

8. The more time a team spends learning to work together, the better job they will do. SA A D SD

9. Team leaders should be chosen democratically. SA A D SD

10. More personal growth takes place when team members spend a lot of time discussing their task than when they don't. SA A D SD

11. Team participation usually leads to increasing one's professional skills. SA A D SD

12. Team members probably work together better if they don't see much of each other outside the time setting. SA A D SD

The next group of statements refers more specifically to teams for health care delivery.

13. The presence of all team members with a patient overwhelms the patient and violates patient privacy. SA A D SD

14. Rotating leadership is the most effective way to run a team. SA A D SD

15. Detailed planning at the end of each clinic for what will happen the next week destroys spontaneity of the teams. SA A D SD

16. Families have more confidence in a team than in just one person. SA A D SD

17. Having a team do health asssessments may give a family a false impression of the kind of care available to them. SA A D SD

18. It is difficult for patients to trust all members of a health care team. SA A D SD

19. Health care teams are the best possible way of delivering quality health care. SA A D SD

20. To work as a team means all team members must be present for all activities during the clinic session. SA A D SD

21. When one person carries out a specific responsibility assigned by the team, that person can do it in whatever way he or she feels is best. SA A D SD

22. No team member should criticize another team member's performance in front of patients. SA A D SD

23. All functions undertaken in the clinic should be undertaken by prior team decision. SA A D SD

24. It doesn't matter who performs functions in the clinic so long as team members all share in discussion of the findings. SA A D SD

25. Working as a team takes more time than working as individuals. SA A D SD

People have various ideas about roles of members of a health care team. These statements reflect your opinions about the roles and functions of members of a professional health care team.

26. Doctors should make final decisions about patient care because they will ultimately be held responsible by the public. SA A D SD

27. Most NP/PAs can do just as good a physical exam as most doctors. SA A D SD

28. Social workers don't really belong on health care teams. SA A D SD

29. Most doctors don't really view a person as a whole but only look at the symptoms. SA A D SD

30. NP/PAs should always be supportive of the doctor's views even when they disagree. SA A D SD

31. The doctor should always explain to other members of the team what he or she is doing with the patients. SA A D SD

32. It is not important for doctors and NP/PAs to understand how lab tests are run, as they only need the results. SA A D SD

33. Without a psycho-social person on the team, other team members could not understand the full impact of psycho-social factors on the physical health of a person. SA A D SD

34. Most nursing students probably know as much about illness as most medical students. SA A D SD

35. Teams should decide who can do what best and assign responsibilities without considering traditional roles. SA A D SD

36. The record keeping system is really the concern of the physician and the rest of the team does not need to be concerned about that. SA A D SD

37. Pscho-social personnel know less than the physicians do about which physical symptoms signal emotional problems. SA A D SD

38. When ideas differ about what course of treatment is called for, the team should always negottiate, study, and discuss till a team concensus is reached. SA A D SD

39. When a difficult diagnosis needs to be discussed with a family, only the physician should do it. SA A D SD

Yee, Roberta, Curriculum for Interdisciplinary Training Programs with Health Profession Students, American Medical Student Association Foundation. Developed under Grant No. MB 00104-01 awarded by the Office of Interdisciplinary Programs, Bureau of Health Manpower, Dept. of HEW. Reprinted with permission.

HEALTH CARE TEAM SURVEY WORKSHEET

Team Areas of Agreement

Areas of Disagreement	Tolerable	Major Obstacle in Need of Resolution

Exercise 2: Are we a team? Do we want to be a team?

Purpose:

Teamwork requires interdependent operation in order to accomplish a goal. Developing a team requires commitment on the part of the team members to work together. The purpose of this exercise is to determine what kind of practice exists at the present time, and to identify changes that teamwork might make which would improve patient care. The exercise should help the participants determine if they are presently functioning as a team and if they feel that teamwork could help them improve their practice.

Time Required: Approximately 1 1/2 hours. (If diagrams and descriptions are completed before the session begins, alow one hour for the discussion.)

Instructions:

1. Prior to the session each participant recalls and describes a patient encounter that occurred in the last week. The description should begin with the patient's first contact with the staff for that particular visit (obtaining the appointment) and end when the patient leaves the office or clinic. The description should include who the patient encountered, what each individual's role was in providing service to the patient, and problems that occurred during the encounter. These should be recorded on the worksheet.

2. The participants share their descriptions and worksheets.

3. From this information they identify who patients encounter to obtain service from the practice, the role of each individual in providing the service, and problem areas in the patient's encounter.

4. The facilitator directs the participants to examine who the patient encounters in the practice and, from that, information to determine who is on the team; what roles people played in the encounter to determine if these were appropriate; what problems occurred in the encounter to determine areas in the practice the participants need to improve; and if there were instances where teamwork would have helped improve the patient's experience with the practice and the care he or she received to help the participants determine if there are potential benefits to themselves and their patients by becoming a team.

Name and Role of Individual Encountered by Patient	Problems in Encounter	Areas Where Teamwork Would Have Improved Encounter

SECTION B. HEALTH CARE TEAM DEVELOPMENT: ISSUES AND INFLUENCES

Overview

This section contains four readings and four exercises. Instructions indicate which readings and bibliography selections should be read before each exercise. Since Exercise 1: "Values that Determine My Practice" requires that the team members reveal a great deal of themselves to one another and have developed a level of trust in one another, the faculty, team consultant or team may decide to dealy this type of exercise until later. If all exercises are completed, the group meeting will take a minimum of 5 hours.

Readings

1. "Principles of Medical Ethics, A.M.A."
2. "The Code for Nurses"
3. "Examples of Interprofessional and Intraprofessional Conflicts"
4. "Team Development: Issues and Collaboration"

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Exercises:

Exercise 1:	Values that Determine my Practice.
Exercise 2:	Effects of Professionalism and Socialization on Team Development.
Exercise 3:	Organizational Influences on Team Practice.
Exercise 4:	NP/PA-MD Team Development Issue Scenarios.

Reading

An individual's values are created by his or her socialization through family, community, educational institutions, professional organizations, work experiences, and philosophies. "The Principle of Medical Ethics" and "The Code for Nurses" are examples of these influences and should be read before Exercise 1: "Values that Determine my Practice."

THE CODE FOR NURSES[18]

1. The nurse provides services with respect for the dignity of man, unrestricted by considerations of nationality, race, creed, color, or status.

2. The nurse safeguards the individual's right to privacy by judiciously protecting information of a confidential nature, sharing only that information relevant to his care.

3. The nurse maintains individual competence in nursing practice, recognizing and accepting responsibility for individual actions and judgments.

4. The nurse acts to safeguard the patient when his care and safety are affected by incompetent, unethical, or illegal conduct of any person.

5. The nurse uses individual competence as a criterion in accepting delegated responsibilities and assigning nursing activities to others.

6. The nurse participates in research activities when assured that the rights of individual subjects are protected.

7. The nurse participates in the efforts of the profession to define and upgrade standards of nursing practice and education.

8. The nurse, acting through the professional organization, participates in establishing and maintaining conditions of employment conducive to high-quality nursing care.

9. The nurse works with members of health professions and other citizens in promoting efforts to meet health needs of the public.

10. The nurse refuses to give or imply endorsement to advertising promotion, or sales for commericial products, services, or enterprises.

PRINCIPLES OF MEDICAL ETHICS[19]

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1

The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2

Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3

A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5

A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6

A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7

In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9

A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiences he may observe in the characater of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10

The honored ideals of the medical profession imply that the responsibilities

of the physician extend not only to the individual, but also to society where these responsibilities deserve his interst and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

The physician, physician assistant and nurse practitioner have all experienced different socialization processes. They are also in professions which are at different stages of development. Within their own and their team's development, they will be exposed to pressures from inter-professional and intra-professional conflicts that can adversely affect their team function. The examples of inter-professional and intra-professional conflicts are intended to make them aware of this problem. They can be read before Exercise 2: "Effects of Professionalism and Socialization on Team Development and Operation."

PA REGS UNDERGO CHANGE

The Physician's Assistant Examining Committee's (PAEC) review of all PA regulations has advanced another step. The Committee drafted recommendations for highly significant changes based on testimony gathered in public hearings and on its own study of existing regulations.

Many of the important changes were suggested by CAPA in the public hearings held last fall. The Committee's recommendations will go to the Division of Allied Health and to additional public hearings this summer. Some of the proposed changes are summarized below:

1. Remove the "laundry-list" of tasks allowed for PAs and substitute authority for the supervising physician to delegate tasks to the PA which are within the scope of practice of that physician and that do not jeopardize the patients' health and welfare.

2. Remove the ('s) from physician's assistant in all regulations.

3. Remove the requirement of no separate billing by the physician assistant (PA).

4. Remove the requirement of informed consent for PA surgical services other than for PA students.

5. Remove the requirement of listing the supervising physician's name in advertising professional services. Advertising may not, however, imply independent practice.

6. Remove "primary care" from the general definition of a physician assistant.

7. Remove the definition of a primary care physician.

8. Allow training programs more discretion in their activities.

9. Change the minimum residency requirement for students from one year to three months.

10. Remove the name tag requirement for PAs other than student PAs.

11. Remove the general definition of specialist PAs and the specific specialty PAs except for Emergency Specialty PAs.

12. Remove requirements for specialty programs which enroll already certified PAs.

13. Retain specialty PA regulations only for already certified specialist PAs.

Because of the dramatic nature of the changes recommended, much more discussion is likely in future public hearings. Local PA groups should consider meeting to discuss the implications of these changes and inform other PAs in the state about them.

Henry, Steven: "PA Regulations Undergo Change," The California Academy of Physician Assistants Newsletter, April, 1982. Reprinted with permission.

MN FOR NPs?

The National League for Nursing believes that the nurse practitioner should hold a master's degree in nursing in order to ensure competence and quality care. Furthermore, the League believes that the nurse practitioner should be educated within nursing's formally recognized educational structure where emphasis in graduate nursing study would be placed on an expanded, specialized nursing function, rather than on the performance of certain medical tasks. Nursing's educational model teaches students to assess and care for the individual thoroughly, recognizing the individual's psychosocial dimension, socioeconomic status, and day-to-day behavior patterns, not just his/her physical status and medical history. Since the nurse practitioner role has a high degree of autonomy in and out of institutions, the League believes it is essential that these practitioners have advanced education and training in graduate nursing education programs to prepare them for independent decision-making and provide them with a specialized, in-depth knowledge base.[1]

My first reaction to the above statement was surprise. I was amazed that an organization opposed to baccalaureate education as the entry level for professional nursing practice was endorsing graduate education for specialized nursing expertise.

The document's preamble lists confusion and controversy as the reasons for the position paper. It states a nurse practitioner in a variety of settings may be:

1. A registered nurse who has been trained by a physician "on the job" in physical assessment.
2. A registered nurse who has had a short course in physical assessment given by a school of nursing or a school of medicine.
3. A graduate of a baccalaureate program that includes physical assessment.
4. A graduate of a masters program that includes physical assessment.

Nurse practitioners themselves want to eliminate the controversy of what a nurse practitioner is. Moving nurse practitioner education into master's programs, however does not, insure uniformly educated or qualified practitioners. The current programs are certainly not alike in content, teaching methods or faculty composition.[2]

As noted in the League's document nurse practitioners' education has changed in the last 15 years. "In many cases, nurse practitioner curricula now focus on the aspects of patient care that come under the discipline of nursing such as psychosocial aspects of care, health education and counseling, and repatterning of behavior to healthier modes. . . . Many health policy makers have projected that, as a result of the nurse practitioner movement, nurses will soon become recognized as the nation's major group of primary care specialists."

Nurse practitioners are primary health care specialists just as clinical specialists are nurse specialists in tertiary care settings. The concept of nursing clinical specialization and its rooting in graduate nursing education are applicable to primary health care. This is an acceptable argument for setting the master's degree as the entry level for nurse practitioners. But, the premise assumes entry level for generalists is the baccalaureate degree.

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1. National League for Nursing Positions Statement on the Education of Nurse Practitioners. New York, National League for Nursing (October) 1979.
2. Cruikshank BM, Clow TJ: Current Status of PNP Education Pediatric Nursing 6:9-13 (January/February) 1980.

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Brown, Barbara S.: Editorial "MN for NPs," Pediatric Nursing, May/June, 1980, p. 7. Reprinted with permission.

PAs and (Gulp!) NPs: They work

One of the most exciting aspects of the physician assistant profession is the simple fact that "it works." Given the volume of destructive, divisive assaults on the profession, PAs could take pride in having merely *survived.* It is no accident that the PA profession has flourished. This is the result of hard working, creative leadership that has always managed to make the most of the fact that when a patient is seen by a PA, the result, whenever the issue has been studied, has been cost-effective, quality health care. It is always helpful to remind oneself of this simple notion, particularly if you find yourself embroiled in an emotional argument involving the profession. Recently, this happened to me.

The occasion was a roundtable for editors of selected journals published for hospital administrators, physicians, and nurses, sponsored by AMI, a leading investor-owned health services company that owns, manages, or operates more than 100 hospitals. The roundtable focused on the "apparently conflicting interests of different professional groups," primarily those representing medicine, nursing, administration, government, and medical technology. I represented two journals that I edit and helped found: ***Physician Assistant*** and ***Hospital Physician,*** a journal for resident physicians.

One of the most heated exchanges at the roundtable occurred following a presentation by George Goldberg, M.D., a staff member of the Rand Corporation, and co-author of the Rand report on physician extenders (both PAs and nurse practitioners) in the Air Force. As regular readers of ***Physician Assistant*** know, the Rand report gave PAs and NPs exceptionally high grades: it found that PAs and NPs delivered care comparable or possibly superior to physicians alone, and documented significant cost savings.

Criticism of Dr. Goldberg did not address the substance of his report. Rather, it came from nurses who were "outraged" and "insulted" by Dr. Goldberg's lumping together of PAs and NPs. "PAs are an extension of ***medicine,*** nurse practitioners are an extension of ***nursing,***" Dr. Goldberg was told. Nursing is an "independent" profession; PAs were created by medicine and dependent on physicians.... Surely, this script sounds familiar!

Dr. Goldberg, of course, was not new to this debate. He responded that the study, to be at all meaningful, did have to make a distinction between those practitioners whose training apparently entitled them to practice a certain level of patient care, and those practitioners (he cited "licensed massage therapists") whose training did not. When the study group scrutinized the situation, they concluded that at the level of patient contact there were more similarities than differences between PAs and NPs. NPs may consider themselves "independent," but few actually work that way. The "dependent" nature of PA practice can be equally elusive to define, although the physician's ultimate accountability for the patient is much more clear.

Clearly, the differences between PAs and NPs have become more important to the PA and NP professions than they are to patients and the government. The process of credentialing each profession independently in an attempt to quantify the differences has done nothing to reduce the confusion. Probably the most unfortunate consequence has been to confuse potential employers of both PAs and NPs.

I confess that I have no magic solution to this dilemma. But we should try and keep it in perspective. After all, if Rand doesn't care, if the government doesn't care, if ***patients*** don't seem to care..... why should we be so concerned?

Peter Frishauf is editor of ***Physician Assistant*** and ***Health Practitioner.***

Frishauf, Peter: "PAs and (GULP!) NPs: They Work," Physician Assistant, 5 (7):6 (July)1981. Reprinted with permission.

The goals of the team can best be met if each person is allowed to contribute all the skills they have to the task. Team issues such as arbitrary use of power and different values can interfer with the development of a collaborative practice. This reading identifies some issues that may disrupt team development and lists the characteristics of a good collaborator; understanding the characteristics of collaboration will help the team evaluate the scenarios in Exercise 1.

TEAM DEVELOPMENT: ISSUES AND COLLABORATION

Among team development issues that have been identified as being significant in NP/PA-MD health teams are power, authority, autonomy, dependency, competition, territoriality, leadership, supervision, sex, culture, intimacy, norms, values, attitudes, and ethics. Unless these issues are addressed and resolved, the effectiveness of one team member or of the whole team effort may be significantly impaired.

Collaboration is a cooperative venture based on shared power and authority. It assumes power based on a knowledge or expertise as opposed to that based on status, role, or role functions.[20]

The use of arbitrary power in a team can result in members being dependent, submissive, or rebellious and may cause a loss of time, cost by enforcement, alienation, stress, and diminished authority of the power figure.

Individual team members' norms, values, attitudes, and ethics greatly influence the team's development in these areas. The team must develop its own norms, values, attitudes, and ethics in order to avoid constant conflict.

Understanding the principles of collaboration will give the team guidance in dealing with issues in NP/PA-MD team development.

A person who is a good collaborator has the following skills and attitudes:

1. Is willing and able to use feedback and introspection to modify self-image.
2. Feels capable and able to accept responsibility in own professional role.
3. Is willing to change conception of roles, duties, and responsibilities of own profession based on new information.
4. Has mastered and continues to develop in the essential skill areas of own profession.
5. Is willing and able to learn what others (providers and clients) can do and cannot do in different situations.
6. Is willing and able to accept and include others (providers and clients) as appropriate to the situation.
7. Is able to identify, define, and analyze goals.
8. Is able to approach each setting with flexibility and openness.
9. Is willing to modify behavior to be consistent with the situation.
10. Is willing to modify the setting to facilitate interrelationships between self and others.
11. Is willing to open and maintain communication with others.
12. Is willing to understand another's point of view, values, and feelings without being judgmental.
13. Is willing to build trusting relationships and to engage in and resolve conflicts.
14. Is willing to take risks in communicating with others and in decision making.
15. Is willing to assume leadership and accept the leadership of others, depending on the situation.
16. Is willing to both initiate and accept change.[21]

Exercise 1: Values That Determine My Practice[22]

Purpose

The individual team members' values affect the team's performance and the team in turn influences individual team members' values. The purpose of this exercise is to help the team members identify their own values, become aware of the values of others on their team, and begin to identify the values of the team. This exercise requires that individuals trust each other. Faculty may decide to delay this type of experience if the team members have not had time to develop this trust.

Time required: If value lists, ranking and descriptions are completed before the session, approximately 1 1/2 hours will be required. If these are completed during the session at least 2 hours will be needed.

Instructions:

1. Prior to the session, participants will:

   - Read: Brill: Teamwork: Working Together in the Human Services, and/or Hortwitz: Team Practice and the Specialist, pp. 43-49; "Principles of Medical Ethics"; and the "Code for Nurses".

   - Write a description that depicts the work situation that they would find most satisfying, and identify the values that would be fulfilled by that situation.

   - Use the description to help him or her to develop a list of his or her values (for example, competence, respect) that influence his or her practice.

   - Ranks the values in order of importance to him or her (number limited to ten)

List	Rank
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

2. At the session the faciitator encourages the team members to share their values lists and the insights about their values and needs that were gained from reflecting on and ranking their values.

3. The facilitator then directs and assists the team in developing and ranking a team values list.

4. The team values are recorded and can be reviewed at a later time as part of the team's assessment.

Adapted from Stech and Harman(22)

Exercise 2: Effects of Professionalism and Socialization on Team Development

Purpose

Professionalism has both helped and hindered the development and function of the health care team. The purpose of this exercise is to alert the participants to the effect of their own professionalism and socialization and to the interprofessional and intraprofessional conflicts that may affect their team's development and practice.

Time required: Approximately one hour.

Instructions:

1. Prior to the session the participants will have read:

   Ducanis and Golin: The Interdisciplinary Health Care Team, Chapter 3 and 7; Luire: "Nurse Practitioners: Issues in Professional Socialization," Journal of Health and Social Behavior; Budetti, Frey, and McManua: "Pediatricians and Family Physicians: Future Competition for Child Patients?" The Journal of Family Practice, and "Example of Intraprofessional and Intraprofessional Conflict ".

2. Each team member brings to the team session a journal article that reflects the present stage of professionalism of his or her profession, socialization processes they have experienced that may affect the team, or a significant interprofessional or intraprofessional conflict.

3. Team members give a short synopsis of the articles to the team.

4. The team discusses the potential effect of the team members' present stages of professionalism, the effect of their professional socialization, and present interprofessional and intraprofessional conflicts on a NP/PA-MD team and on their team specifically.

Exercise 3: Organizational Influence on Team Practice[23]

Purpose

The purpose of this exercise is for the team to recognize its position within the institution or organization, and to identify institutional philosophies and policies that support or impede team practice. Health care teams can be found in private practice settings, but often are based in larger organizations such as a hospital, HMO, or clinic. How the team operates is markedly influenced by the philosophy, structure, and policies of the organization.

Time required: Approximately one hour.

Instructions:

1. Prior to the session the participants will have:
   - Read: Ducanis and Golin: The Interdisciplinary Health Care Team, A Handbook, Chapter 5.
   - Have obtained organizational charts of their institution, their institution's philosophical statements about team practice, job descriptions for the team members in the organization, and any other policy statements that might affect their team's development. The team may divide up the work of obtaining the information and each team member may give a short summary on the information they have obtained or each team member may obtain and have read the information.
2. The team uses the information to draw a sociogram of the team and its place in the organization.
3. The team uses the sociogram and their information regarding the organization to discuss their position within the organization and institutional philosophies and policies that support or impede team practice.
4. Policies or procedures that impede team practice should be discussed further in a problem solving session.

Adapted from Stech and Ratcliffe(23).

Exercise 4: NP/PA-MD Team Development Issue Scenarios

Purpose

The purpose of the exercise is for the team to identify issues that can affect team development and to determine the issues that are disrupting their own development.

Time required: 1 1/2 hours.

Instructions:

1. Prior to the session team members should read the bibliography selections:
   Dacket and Sullivan: "Autonomy in Practice," The Nurse Practitioner; Edmunds: "Nurse Practitioner - Physician Competition," The Nurse Practitioner; and Eichham: Becoming: The Actualization of Individual Differences in Five Student Health Teams.
2. One team member or facilitator reads the scenario and the questions to the team.
3. The team members discuss their answers to the questions, give their own reaction to the situation and identify if the issue is a team problem. If the issue is causing team conflict the team should plan a conflict resolution session to work on the problem.

NP/PA-MD TEAM DEVELOPMENT ISSUE SCENARIOS

Scenario #1 - It's My Decision

Mary, PA, and Sue, MD, have a joint family practice. Mary sees many of the young women for birth control counseling. After much discussion with Sally, a highly motivated 16-year-old, Mary advises her on the use of the fertility awareness method and the diaphragm. The diaphragm will be used while Sally is learning the F.A.M. and at unsafe times. On reviewing Sally's chart, Sue tells Mary that she should not advocate the F.A.M. for 16-year-olds because it will not work.

Questions

1. What issues are present here?
2. If you were Mary, how would you feel?
3. What would have been a better approach for Sue to take?
4. Does this happen in your team?

Scenario #2 - Reverse Sexism?

John, MD, and Jane, FNP, are in co-practice. Jane tells the nurses to give all the young female patients with counseling and gynecological problems to her to see as she is sure that they would not want to see a man. The nurse directs 18-year-old Kim, who has severe pelvic pain, bleeding, and a high temperature, to see John as she thinks Kim's problems requires a doctor's expertise. John agrees with the nurse. Jane becomes very upset and insists that woman should have a choice to see a woman provider.

Questions

1. What issue(s) are present here?
2. How would you approach the issue of the patient's choice of provider?
3. Is this a problem in your team?

Scenario #3 - Too Many Supervisors

Ken, FNP, and Sharon, MD, are in team practice at the Long Bow Hospital Ambulatory Care Clinic. They are developing standardized procedures in compliance with the Nurse Practice Act. The clinic nursing supervisor states that since Ken is a nurse, she must approve the procedures. Sharon states that because the procedures are medical, no nurse needs to approve them. She says they should be approved by the medical director. The administrator of the clinic states that he is in charge of the clinic, so he needs to approve them.

Questions

1. Who should evaluate and supervise the team, the NP, PA, the MD?

2. How would you deal with establishing standardized procedures in this situation?

Scenario #4 - Friends

Sara, PA, works with a couple, Judith and Steve, both MDs, in their private practice. They are all friends and frequently socialize together. The Smiths trust and praise Sara, stating that she can handle anything. Whenever they wish to have time together or need time to deal with each other, they take sudden, unplanned absences, sometimes leaving Sara alone to handle things. There are no back-up arrangements for Sara; and unplanned absences of Judith and Steve cause problems for Sara, the office staff, and patients.

The team feels that the other MDs in the area do not trust PAs and so would not be available for back-up.

Questions

1. What are the issues?

2. If you were Sara, how would you handle the situation?

Scenario #5 - Dependence

Mark, PA, becomes indignant when Emily, MD, suggests that they work out some protocols for the practice. He states that protocols are "cook book medicine" for people who can't think and that PAs do not have to have protocols, only NPs do. Nevertheless, Mark chooses to consult Emily on every patient he sees.

Questions

1. What are the issues?

2. How would you handle the situation if you were Emily?

Scenario #6 - It's Mine

Sam, FNP, and George, Family Practice resident, 3rd year, are in a joint practice at the UC Hollywood Clinic. George has just started doing some family counseling in the residency. On reviewing Sam's records, he finds that Sam has done a family visit with Mrs. White, her husband, and their daughter. Sam has recorded a family contract and plan in the chart. George tells Sam that he cannot do family therapy since he is not an MD. Sam states that evaluation and counseling of families is nursing and that medicine is trying to take that over, too!

Questions

1. What is nursing?
2. What is medicine?
3. Who decides who does what?
4. Is role more important than outcome?
5. Is there hidden anger about issues similar to this on your team?

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MODULE II

Roles and Barriers to Team Development

Roles and Barriers to Team Development

Physicians, physician assistants, and nurse practitioners come to the team with role expectations for themselves and for each other. These expectations may be based on the legal responsibility they have to the patient because of their profession, their interpretation of their responsibility and tasks, or roles they have taken on as a member of the team. These expectations are often based on socialization by their previous life experiences, their educational programs, and the philosophies of their professions. Their understanding of the role of their other team members is often based on a limited knowledge of the others' background, education or skills.

The legal relationship of the nurse practitioner, physician assistant, and physician mandates interdependency. Teamwork requires that these providers develop an understanding and agreement about each other's roles and areas of role overlap and attempt to minimize the barriers to practice. Without this, dissatisfaction, frustration, conflict, and limitations on the team's potential for providing care to their patients can occur.

This module contains readings and exercises to help the physician, physician assistant, and nurse practitioner gain more knowledge about each other's prescribed role and personal interpretation of that role, about each other's qualifications to practice and barriers to practice. Inclusion of other team members such as nurses, social workers, and psychologists in this process helps the NP/PA-MD team to recognize and learn how to utilize the skills of other team members. It will also help the other team members know what the NP/PA team has to offer the client. Unfortunately, it is beyond the scope of this manual to provide information regarding the roles of all the team members.

Module III contains more specific exercises for role negotiation of conflict around prescribed and assumed roles.

OBJECTIVES

Participants will describe each team members:

- educational preparation
- skills
- responsibilities and limitations
- legal status
- scope of practice

Participants will identify and communicate personal interpretations and preferences in carrying their profession to the team.

Participants identify the economic, manpower, legal and social issues that influenced the development of the nurse practitioner, physician assistant, Family Practice physician, and Primary Care physician roles and will describe the potential effect of the present state of these issues on the future development of the roles.

Participants will describe reimbursement, funding, hospital privileges, and prescribing policies and their influence on team practice.

Participants will identify the areas of role overlap and of specialization of the nurse practitioner, physician assistant, and physician in the team.

Participants will identify conflicts caused by role expectations, limitation, role overlap, or barriers to practice.

ROLES AND BARRIERS TO TEAM DEVELOPMENT

Overview

This module contains five readings and two exercises. If all the exercises are completed, the group meeting will take about four hours. Role negotiation exercises are found in Module III.

Readings

1. "Business and Professions Code, Chapter 6, Nursing"
2. "Medical Quality Assurance Physician Assistants"
3. "Overview of Legal Issues for Nurse Practitioners and Physician Assistants"
5. "Malpractice"

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Exercises

Exercise 1: Nurse Practitioner, Physician Assistant, and Primary Care Physician's Roles

Exercise 2: Barriers to the Utilization of the NP/PA

The Nurse Practice Act and Physician Assistant Practice Act lay out the legal responsibilities and limitations of each profession. Reading them will help team members understand and identify the roles of their team members. They should be read before doing Exercise 1: Nurse Practitioners, Physician Assistants, Primary Care Physicians Roles.

Assembly Bill No. 2002

CHAPTER 406

An act to amend Section 2725 of the Business and Professions Code, relating to the practice of nursing.

[Approved by Governor July 10, 1980. Filed with
Secretary of State July 11, 1980.]

LEGISLATIVE COUNSEL'S DIGEST

The people of the State of California do enact as follows:

SECTION 1. Section 2725 of the Business and Professions Code is amended to read:

2725. In amending this section at the 1973–74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973–74 session to provide clear legal authority for functions and procedures which have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems which provide for collaboration between physicians and registered nurses. Such organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

The practice of nursing within the meaning of this chapter means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill, and includes all of the following:

(a) Direct and indirect patient care services that insure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(b) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(c) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(d) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalties, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

"Standardized procedures", as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses;

(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code. Such policies and protocols shall be subject to any guidelines for standardized procedures which the Division of Allied Health Professions of the Board of Medical Quality Assurance and the Board of Registered Nursing may jointly promulgate; and if promulgated shall be administered by the Board of Registered Nursing.

Nothing in this section shall be construed to require approval of standardized procedures by the Division of Allied Health Professions of the Board of Medical Quality Assurance or the Board of Registered Nursing.

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BUSINESS AND PROFESSIONS CODE

2725.1. The scope of practice of a registered nurse shall include the prescribing, dispensing, and administration of drugs or devices when the nurse is engaged in an experimental health manpower project authorized under Article 18 (commencing with Section 429.70) Chapter 2 of Part 1 of Division 1 of the Health and Safety Code and is acting within the scope of such project as defined by the Office of Statewide Health Planning and Development. No registered nurse shall prescribe drugs except under the general supervision of a licensed physician and surgeon.

This section shall remain in effect until January 1, 1983, and on such date is repealed.

2726. Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

2727.5. A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of her employment shall not be liable for any civil damages as the result of acts or omissions by such person in rendering the emergency care.

This section shall not grant immunity from civil damages when the person is grossly negligent.

Article 8. Nurse Practitioners

2834. The Legislature finds that various and conflicting definitions of the nurse practitioner are being created by state agencies and private organizations within California. The Legislature also finds that the public is harmed by conflicting usage of the title of nurse practitioner and lack of correspondence between use of the title and qualifications of the registered nurse using the title. Therefore, the Legislature finds the public interest served by determination of the legitimate use of the title "nurse practitioner" by registered nurses.

2835. No person shall advertise or hold himself out as a "nurse practitioner" who is not a nurse licensed under this chapter and does not, in addition, meet the standards for a nurse practitioner established by the board.

2836. The board shall establish categories of nurse practitioners and standards for nurses to hold themselves out as nurse practitioners in each category. Such standards shall take into account the types of advanced levels of nursing practice which are or may be performed and the clinical and didactic education, experience, or both needed to practice safely at those levels. In setting such standards, the board shall consult with nurse practitioners, physicians and surgeons with expertise in the nurse practitioner field, and health care organizations utilizing nurse practitioners. Established standards shall apply to persons without regard to the date of meeting such standards. If the board sets standards for use of nurse practitioner titles which include completion of an academically affiliated program, it shall provide equivalent standards for registered nurses who have not completed such a program.

2837. Nothing in this article shall be construed to limit the current scope of practice of a registered nurse authorized pursuant to this chapter.

Article 8. Standards for Nurse Practitioners

1480. Definitions.

(a) The nurse practitioner is a registered nurse with additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program conforming to Board standards. The nurse practitioner shall function within the scope of practice as specified in the Nursing Practice Act as it applies to all registered nurses.

(b) Primary health care is that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

(c) Clinically competent means that one possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice.

1481. Categories of Nurse Practitioners.

A registered nurse who has met the requirements for holding out as a nurse practitioner as defined in Section 1482 may be known as a nurse practitioner and may place the letters "R.N., N.P." after his/her name alone or in combination with other letters or words identifying categories of specialization, including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner.

1482. Requirements for Holding Out as a Nurse Practitioner.

(a) Active licensure as a registered nurse in California; and

(b) One of the following:

(1) Successful completion of a program of study which conforms to Board standards; or

(2) Certification by a national or state organization whose standards are equivalent to those set forth in Section 1483; or

(3) A nurse who has not completed a Nurse Practitioner Program which meets Board standards as specified in Section 1484, shall be able to provide

(A) documentation of remediation of areas of deficiency in course content and/or clinical experience; and

(B) verification by a nurse practitioner and by a physician who meet the requirements for faculty members specified in Section 1484(c), of clinical competence in the delivery of primary health care.

1483. Request for Evaluation of Credentials.

The Board will upon request provide an evaluation of an individual's credentials to determine conformity to Section 1482(b)(3). It is emphasized that this evaluation is not mandatory, but will be voluntary with the individual.

1484. Standards of Education.

The program of study preparing a nurse practitioner shall meet the following criteria

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This reading only contains portions of the Nurse Practice Act that pertain specifically to the Nurse Practitioner. The entire Nurse Practice Act can be obtained from the Board of Registered Nurses.

ARTICLE 1. General Provisions

1399.500. Citation and Authority.

This chapter may be cited and referred to as the "Physician's Assistants Regulations." This chapter is adopted pursuant to the provisions of Sections 3502, 3510, 3514, and 3516.5 of the Business and Professions Code in order to implement, interpret and make specific provisions of the Physician's Assistants Practice Act, Chapter 7.7 (commencing with Section 3500), Division 2 of said code, relating to the practice of physician's assistants.

1399.501. Location of Office.

The principal offices of the Division of Allied Health Professions and the Physician's Assistants Examining Committee for purposes of this chapter are located at 1430 Howe Avenue, Sacramento, California 95825.

1399.502. Definitions.

For the purposes of the regulations contained in this chapter, the terms

a. "Board" or "Division" means the Division of Allied Health Professions of the Board of Medical Quality Assurance of the State of California.

b. "Committee" means the Physician's Assistant Examining Committee.

c. "Code" means the Business and Professions Code.

d. "Physician's assistant" means either a "primary care physician assistant" or a "(insert specialty) physician's assistant." (See Sections 1399.520 and 1399.540 for further definition.)

e. "Trainee" means a person enrolled in an approved program of instruction for physician's assistants.

f. "Approved program" means a program for the training of physician's assistants which has been approved by the committee.

1399.503. Delegation of Functions.

a. The power and discretion conferred by law upon the division to request investigations of alleged violations of the code pertaining to any practice under the jurisdiction of the board; receive and file accusations; issue notices of hearing, statements to respondent and statements of issues, receive and file notices of defense; determine the time and place of hearing pursuant to Section 11508 of the Government Code; issue subpoenas and subpoenas duces tecum; set and calendar cases for hearing and perform other functions necessary to the dispatch of business of the division in connection with proceedings under the provisions of Section 11500 et seq. of the Government Code (Administrative Procedure Act), prior to the hearing of such proceedings; and the certification and delivery or mailing of copies or decisions under Section 11518 of the Government Code are hereby delegated and conferred upon the executive director of the board or in his or her absence, the assistant executive director or program manager for enforcement.

b. The functions listed above which are under the jurisdiction of the committee are hereby delegated and conferred upon the executive officier of the committee or in his or her absence, the executive director of the Board.

1399.504 Prior Approval or Certification to Practice as a Physician's Assistant.

No person shall practice as a physician's assistant in this state without prior approval or certification by the committee.

1399.505. Prior Approval to Supervise.

No licensed physician shall supervise a physician's assistant in the practice of medicine or surgery without the prior approval of the board.

1399.506. Filing of Applications.

a. Applications for certification as a physician's assistant shall be filed on a form provided by the committee at its Sacramento office and accompanied by the fee required in Sections 1399.610 or 1399.611.

b. Applications for approval to supervise a physician's assistant shall be filed by the proposed physician-supervisor on a form provided by the division at its Sacramento office and accompanied by the fee required in Sections 1399.610 or 1399.611.

c. Applications for approval of programs for the education and training of physician's assistants shall be filed on a form provided by the committee at its Sacramento office and accompanied by the fee required in Section 1399.614.

1399.507. Examination Required.

Except as provided in these regulations, no person shall be certified as a physician's assistant who has not successfully completed an examination approved by or administered by the Committee. For purposes of this article, successful completion requires that the applicant has achieved the passing score established by the committee for that examination. It is the duty and responsibility of the applicant to cause to be mailed to the committee an "Official Certification of Examination Score" indicating the applicants score on that examination.

1399.508 Interim Approval

The committee may grant interim approval of the application for a proposed physician's assistant provided that the applicant has evidenced that he or she has applied for, and thereafter has taken, the first examination required by Section 1399.507 subsequent to the applicant's successful completion of an approved program. If the applicant fails the examination, the interim approval automatically terminates upon the applicant's receipt of notice of such failure by the committee or by the National Commission on Certification of Physician's Assistants.

1399.509. Billing for Medical Services Rendered by the Physician's Assistant.

The supervising physician or health facility may charge for the services of the physician's assistant as part of the total health care services provided. There shall be no separate billing by the physician's assistant.

1399.510. Patient Informed Consent.

The patient's informed consent must be obtained by the physician's assistant in cases of a surgical nature, except for emergency services, and the patient must be informed of the procedures to be performed by the assistant under the supervision of the primary care physician or specialist physician. Emergency services means those services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, could lead to disability or death (California Administrative Code, Title 22, Section 51056, Subparagraph (a).

No student including preceptees in any approved program for the instruction of an assistant to the primary care physician or specialist physician shall render general medical services to any patient except in emergencies unless said patient has been informed that such services will be rendered by the student. In cases wherein the medical service to be rendered by said student is surgical in nature except in emergencies the patient on each occasion must be informed of the procedure to be performed by that student under the supervision of the program's instructors or physician preceptors and have consented in writing prior to performance to permit such rendering of the surgical procedure by said student. The foregoing requirements pertaining to medical services surgical in nature shall be applied to those instances wherein the student is to assist the instructor or physician preceptor in the rendering of such medical services. It shall be the responsibility of the approved educational program to assue that the instructors of physician preceptors obtain the necessary consent may result in the withdrawal by the Board of approval of the educational program.

1399.511. Notice of Change of Address

Each person or approved program holding a certification, approval or interim approval and each person or program who has an application on file with the board or the committee shall immediately notify the committee at its office of any and all changes of mailing address, giving both the old and new address.

1399.513. Advertising.

(a) Any advertising by a physician's assistant shall be in conformity with Sections 651 and 651.3 of the code. It is unprofessional conduct to disseminate any advertising which is false, misleading, deceitful, fraudulent or has a tendency to mislead the public, or which makes any claims as to the quality or efficacy of the services provided, or which indicates the physician's assistant is or may be engaged in independent practice, or is in violation of Sections 651 and 651.3 of the code.

(b) A licensed physician's assistant may advertise the provisions of professional services authorized to be provided by such license so long as such advertising states the name or names of the physician's assistant's approved physician supervisor or supervisors and does not promote the excessive or unnecessary use os such services.

Article 2. Primary Care Physician's Assistants

1399.520. Definition of Primary Care Physician's Assistant.

For purposes of this article a primary care physician's assistant means a person who has met the requirements of Section 3515, subd. (c), of the code, who has passed the examination for primary care physician's assistants administered by the National Commission on Certification of Physician's Assistants, and who is certified by the committee to perform direct patient care services under the supervision of a primary care physician or physicians approved by the board to supervise such an assistant.

1399.521. Definition of Primary Care Physician.

For purposes of this article, a primary care physician is a physician who evaluates his or her patient's total health care needs, who accepts intial and continuing responsibility therefor, and is approved by the board to supervise primary care physician's assistants.

1399.522. Definition of Supervision.

Supervision of a primary care physician's assistant within the meaning of this article refers to the responsibility of the supervising physician to review with the assistant either in person or by electronic means the findings of the patient's history and physical examination and the performance by the physician's assistant of the tasks or procedures specified in Section 1399.523(b) and (c) on a continuing and timely basis depending on the significance of the findings and the status of the patient. Supervision and review of such procedures or tasks need not be done prior to treatment.

Legal issues surrounding the nurse practitioner and physician assistant as well as the physician's fear of malpractice because of his relationship with a nurse practitioner or physician assistant often cause problems and limitations for the team practice. The "Overview of Legal Issues for Nurse Practitioners and Physician Assistants" gives the team the background to identify these issues. It should be read before doing Exercise 2: "Barriers to the Utilization of the NP/PA."

MALPRACTICE

Physicians or agencies who hire graduate FNPs and PAs usually inform their professional liability malpractice insurance companies of this fact. Companies then cover the FNP/PA for all legal acts, usually at an increased premium, which is currently up to being equivalent to the lowest risk physician, $600-$700 per year (Norcal, Doctors, MIEC). Physicians and Surgeons Exchange and SCPIE (Los Angeles area) cover at no increase in premium.

Nurses can buy independent insurance ($18-25 per year) from:

California Nursing Associatin
Johnson and Higgins, Agents
601 California Street
San Francisco, CA 94108

American Nursing Association
ANA Professional Liability Plan Administration
Lock Box 1778
Des Moines, IA 50306

Maginnis and Associates, Inc.
332 S. Michigan Avenue
Chicago, IL 60604

These nurse policies do not cover the collaborating physician, and the physician's own policy will not cover supervision of an FNP unless that FNP is also explicitly covered by the physician's policy.

There is no policy available to PAs independent of their supervising physician's policy.

Morgan, Walter: "Overview of Legal Issues for Nurse Practitioner and Physician Assistant Students," Legal Packet, NP/PA Program, UC Davis, 1982. Reprinted with permission.

OVERVIEW OF LEGAL ISSUES FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

PHYSICIAN ASSISTANTS

The PAs in California are certified by the Division of Allied Health Personnel under the Board of Medical Quality Assurance. The law which governs PAs was first passed in 1972 and amended in 1975. The law specifies that a PA must come from an accredited Physician Assistant school such as U.C.D. or its equivalent. All PAs must pass the National Certifying Examination for PAs. There is no state exam equivalent. A PA applies to the Board to be allowed to call him/herself a Physician Assistant, and must renew that license every two years. However, no continuing education is required, nor is membership with a national academy required. There is no state requirement for recertification examination.

To practice as a PA, one must have a supervising physician also approved by the Board. This physician applies to the Board for that privilege and must pay a fee to do so. One physician may supervise two, but no more, PAs. There is an arrangement for institutional or group supervision. A physician must be in the same type of practice as the PA. Therefore, a physician who is doing predominantly surgery will not be allowed to supervise a generalist Physician Assistant.

The law specifies the types of procedures and roles a PA may perform, and also states certain exclusions. The constraints do allow for almost everything done in Primary Care and are not currently a barrier, with the exception of dispensing and prescribing of medication which will be discussed separately below.

A PA must report any change in address or supervising physician to the Board immediately.

Any billing to any party for PA-performed services must come through the clinic or the supervising physician; billing cannot come directly to the PA. A certified PA may obtain authorization for Medi-Cal services to be reimbursed. Medicare does not reimburse for PA services. Private insurance is variable on this issue.

When any procedure of a surgical nature is performed on a patient by a PA, a consent form signed by the patient should also include the statement that the procedure will be performed by a physician assistant or student.

The control of a student PA is approximately the same as a graduate PA. The physician does not have to apply to BMQA, but must be approved by the training institution. Student's services cannot be billed for.

FAMILY NURSE PRACTITIONERS

Family Nurse Practitioners practice under the Nurse Practice Act of 1975. This Act by itself does not specify any special procedures or authority for Nurse Practitioners. The law is written for all nurses. This law states that, in as much as nurses often do things which are generally considered "medicine," when their duties overlap the field of medicine, a "standardized procedure" must be written. This procedure must be signed by the nurse, the "collaborating" (not "supervising") physician, and other appropriate individuals, particularly at a licensed facility.

The content of these standardized procedures is spelled out in a separate set of regulations. The document must be on the premises. It does not have to be sent to or approved by any state agency. It must state, among other things, the qualifications of the nurse, the role that nurse is to play, any constraints on her/his performance of that role, the degree of supervision or review to be administered, and how often his/her document is to be updated. It is not clear in the law or the regulations to what depth these procedures must be written. The law alludes to "protocols" or "standing orders" as an option but not a requirement. We interpret clinical protocols (written definitions of disease, diagnoses, and specific outlines of treatment) not to be essential. We are not clear as to whether specific diagnoses and/or conditions to be handled by the nurse need to be specified in the Standardized Procedure. It seems that it must require careful wording so that it is clear that the nurse is operating within his/her constraints as defined locally, without being so narrowly written that straying slightly outside a tight list would leave him/her in jeopardy of "practicing without a license."

The Nurse Practice Act does not specifically exclude any procedures. Presumably, a nurse can do anything in medicine as long as she has a standardized procedure to cover that situation. Other laws, however, specifically exclude dispensing and prescribing of medication. (This subject is dealt with in a separate section below.) The Board of Registered Nurses, on the other hand, has taken the position that the Nurse Practice Act does indeed allow for dispensing and prescribing if the standardized procedures so state. This position is not supported by the Board of Medical Quality Assurance nor the Board of Pharmacy, nor the Attorney General.

The Board of Registered Nursing controls nurses and the Board of Medical Quality Assurance controls physicians, but not nurses. The latter Board does have some slight impact, as they collaborated on the regulations regarding standardized procedures.

Nurse Practitioners are defined in what is nicknamed "holding out" legislation. This states that for any nurse to call him/herself a Nurse Practitioner, he/she must meet the educational requirements specified in the regulations. Currently, those regulations specify a length of training and curriculum which greatly resemble the U.C. Davis Program. The regulations do not require a state or national examination, nor do they require continuing education or any other proof of continued competency beyond the the usual C.E. requirements of all nurses. This law does not establish licensure or certification for nurse practitioners, but merely states that a nurse who calls his/herself a practitioner must meet those requirements. To do so, an FNP does not have to apply to the Board of Registered Nursing but must be able to prove eligibility if challenged. All current U.C.D. graduates are eligible.

It should be clear that the "holding out" legislation does not authorize the Nurse Practitioner to perform any different functions or role than any other nurse. It does not add any constraints or privileges. Any other nurse could do nurse practitioner functions perfectly legally by simply avoiding that title. The "Holding Out" model has been used in the past as a forerunner to certification. Although there is no current legislation aimed at moving toward certification, that may indeed be the case in the future.

The American Nursing Association offers a "certification of excellence" examination for Nurse Practitioners. This examination is not required in California for graduates of California certified schools.

FNP student services may not be billed to Medi-Cal or Medicare. Graduates may bill Medi-Cal through their clinic or physician supervisor, but may not bill Medicare.

DISPENSING AND PRESCRIBING

In general, dispensing of medication and prescribing is limited by law in California to physicians, podiatrists, osteopaths, dentists, and veterinarians. Nurses are specifically excluded from dispensing, unless under "direct supervision by a physician." Direct supervision has been interpreted to mean the physician actually watches each maneuver. The PA law does not specifically exclude dispensing but does exclude prescribing.

Any person, if authorized by a physician, including a clerk, can transmit the physician's prescription by telephone to a pharmacist. Presumably, this means a case by case order by the physician and probably does not include standing orders or protocols. No one can fill out a prescription previously signed by a physician, nor can one other than a physician, dentist, etc., sign one's own prescription or sign a physician's name and initial it. An FNP and PA cannot dispense medication, even samples, without direct observation by a physician.

Preceptors and supervising physicians should be aware of the problems of legality and should countersign each chart which notes a drug was ordered or dispensed for a patient, and be willing to stand behind the FNP/PA should a problem arise.

HOSPITAL PRIVILEGES FOR FNPs AND PAs

Changes in the California Administrative Code, Title 22, in 1980 allow for FNPs and PAs, but not PA students, to function in hospitals legally. These changes were made to make hospital regulations compatible with the existing PA Law and Nurse Practice Act. The regulations, however, cannot authorize a specific FNP or PA to have privileges in a specific hospital. It is the prerogative and responsibility of each hospital to determine individual privileges, whether for physicians or others. A special committee must be established including hospital administrators, physicians and mid-level practitioners in institutions which grant privileges to nurses or PAs (this law talks about nurses with "extended privileges" and does not specify Nurse Practitioners as such). A PA must have a supervising physician in the hospital role, of course. Nurses must have a method of supervision, not necessarily a specific supervisor. This is consistent with the way the Nurse Practice and PA laws are written.

A PA or FNP must apply for privileges to the hospital interdisciplinary committee. A specific list of roles, procedures, and, probably, protocols, will be determined. Very few NPs and PAs have hospital privileges in California. The medical staffs have generally been conservative and unsupportive of these roles. Generally, FNPs and PAs wish only very limited functions, such as following stable patients with progress notes and being involved with discharge planning. It is much less likely that they would want to have or that they would be granted privileges for the initial work-up for acutely ill, hospitalized patients. FNPs and PAs wishing to gain hospital privilegs should be very sensitive to local professional feelings when requesting privileges. It is imperative that they be working with and sponsored by physicians who are of the highest professional regard.

Nursing home privileges are not restricted by state law; however, a similar application process is usually involved. Most often these privileges are more readily obtained, since the stable, chronic disease nature of most of the problems is obvious to the medical staff. The problem in nursing home roles lies mostly with reimbursement. Medicare requires physician service and does not allow for FNP or PA reimbursement for services. Medi-Cal similarly does not reimburse for NP-PA services if the patient is both Medi-Cal and Medicare. The barrier to NP-PAs in nursing homes is, therefore, economic.

REIMBURSEMENT

Patients who pay out of pocket for their primary care may legally pay Nurse Practitioners directly and, through the sponsoring clinics or physicians, pay for the services of PAs. Private insurance companies often reimburse for NP and PA services, but it is not always clear that the companies know that services are actually being performed by FNPs and PAs, since billing usually goes in under the physician's or clinic's name. Often the insurance terminology is "services provided" and does not restrict who actually performs the services. In reality, the insurance companies have no police powers and have no real way of determining short of asking the providers who gave the services or, theoretically, the patients. Insurance company policies may become tighter, and the moral obligation for honest reporting of who provided the care may become more the issue. FNPs and PAs are urged to talk frequently with billing and insurance workers in their own settings to keep abreast with the policies most commonly used in their offices.

Medi-Cal has, since 1979, reimbursed for the services of FNPs and PAs, but not students. The PA and FNP graduate must apply to the Department of Health Services, Division of Provider Enrollment. Almost all services common to primary care are allowable. The reimbursement rate is the same as for physicians.

Medicare is governed by federal law which, when it was written, specified the services of physicians, dentists, etc., and did not allow for NP or PA services. This presents a considerable problem for offices which do considerable Medicare billing.

For combined Medicare/Medi-Cal patients, Medi-Cal will pay essentially nothing.

The only exceptions to the Medicare law are specific rural clinics, certified by HEW as serving health manpower shortage areas ("95-210" clinics), and staffed with acceptable FNP/PA graduates who are remote from their physician's direct supervision most of the time.

The Children's Health and Disability Program (CHDP) does reimburse for NP and PA services when approved in advance, whether or not the physician is on the premises at the time of service. Reimbursement will go to the physician. The Family Planning Grant also allows for services to be performed by FNPs and PAs whose status was described in the original grant application at that site. Assorted other grants and payment systems may or may not reimburse for FNP/PA services and should be clarified locally.

HEALTH CARE PROVIDERS' OBLIGATION TO THE STATE

Physicians and other health care providers are required in the interest of public welfare to report certain conditions. The law specifies it is a crime not to do so. Rape, a suspected battered child, other physical abuse, a birth or a death, and assorted infectious diseases which are potentially communicable to others or which may represent a threat to public health are some of the conditions which require report (see the list from the Bureau of Medical Quality Assurance or the Health Department).

INFORMED CONSENT

Patients have a right to know the qualifications of persons treating them, what procedures are about to be done, what risks are inherent to these procedures, and what are the probable outcomes. These rights are established by legal precedence and by the Statement of Ethics promulgated by a variety of professional organizations. It is not clear whether consent needs to be written or oral, signed or not, or whether it needs to be witnessed. It is generally accepted that any surgical procedure or invasive procedure which has any inherent risk be preceded by a patient-signed consent and kept with the medical records. Presumably, the details of the procedures are stated verbally. It is clear in the law that a Physician Assistant must be identified by a clearly visible name tag, and that any surgical procedure done by a PA include a statement that the PA is doing it in the signed consent. It makes good ethical sense that a patient being treated by a Nurse Practitioner knows very clearly that the FNP is not a physician. All patients should be clear that they have an option to be treated in some other manner.

Treatment of minors, including examination, procedures, and giving medicine, must have the consent of a parent or guardian. The only exception is contraception and treatment of veneral disease, or the general care of an "emancipated minor" - one living away from home.

Morgan, Walter: "Overview of Legal Issues for Nurse Practitioner and Physician Assistant Students," Legal Packet, NP/PA Program, UC Davis, 1982. Reprinted with permission.

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Exercise

Exercise 1: Nurse Practitioner, Physician Assistant, and Primary Care Physician Roles.[1]

Purpose

Nurse practitioners, physician assistants and physicians need to understand each other's responsibilities, qualifications, expectations, and limits in order to give their patients the fullest potential of their team practice. The purpose of this exercise is to acquaint the nurse practitioner, physician assistant, and physician with information and an opportunity to acquire this understanding. They should also identify areas of role overlap and prescribed and presumed roles which may cause conflict within the team.

Time required: Written descriptions - 15 minutes.
Discussion - 2 hours.

Instructions:

1. Prior to the session, participants will have read the following articles from Family and Community Health: Davidson: "Family Practice Physicians -- Their Impact on Improving Family and Community Health," pp. 1-18; Fowkes, Hafferty and Garcia: "The Physician's Assistant Movement - Evolution and Issues," pp. 21-33; and Mentink, Trolinger and O'Hara-Devereaux: "Nurse Practitioner in Primary Care," pp. 35-48.

   The Nurse Practice Act and Physician Assistant Practice Act should also be read.

2. During the session, each team member writes a role description and identifies his or her expectations of the other team member's role (e.g., the physician writes a role description for the physician assistant and vice versa). The role description should include what the team member is expected to do and the limitations he or she perceives for the other.

Adapted from Merry and Allerhand (1).

3. One team member gives his or her written role description to the other. They then delete or add to the description to present how they see the role and share this verbally. Disagreements are discussed. If conflict is perceived, record the problem and plan to utilize Exercise 2: "Role Negotiation Contract" in Module III to assist in resolving the conflict. Record the agreed-upon role description. Team members reverse positions so that all have presented their descriptions and critiqued their team members' descriptions.

Exercise 2: Barriers to the Utilization of the NP/PA

Purpose

The lack of reimbursement from Medicare for other than physician services in skilled care nursing homes and the limitation of the Family Practice physician's hospital practice by specialists are examples of potential barriers to the team's practice created by outside forces. The legal responsibility of the physician in relationship to the nurse practitioner's or physician assistant's practice and the fear of malpractice suits cause limitations within the team practice that can create conflict. The purpose of this exercise is to identify barriers to practice and potential conflict areas for the physician, nurse practitioner, and physician assistant and to clarify the effects of these on the team practice and on the individual team member. The exercise will help the team members identify their positons on these issues.

Time required: A minimum of 2 hours.

Instructions:

1. Prior to the session the participants should have read "Barriers to the Utilization and Practice of Nurse Practitioners and Physician Assistants in California;" Bates: "Doctors and Nurse Practitioners: Conflict and Reward," Annals of Medicine, pp. 702-706; "Overview of Legal Issues for Nurse Practitioners and Physician Assistants," and the GMENAC Report.

2. Team members can take turns describing the present state of the issue from the Barriers List as they see it. The team then identifies the problems that the issue creates for their team. They also present solutions, plan for solutions or develop a position on the issue. These are recorded on the Barrier List. If team members can't agree on ways to handle a problem or if the proposed solution is complex, areas of disagreement should be scheduled to be worked on in the problem solving or conflict management exercises.

BARRIERS LIST

Barrier	Description of Problem Created for Team	Team's Solution or Position on Issue
Difference of perception of role definition--e.g. physician extender, mid-level practitioner, new health professional.		
Physician's acceptance of NP/PA role.		
Reimbursement a. Medical b. Private insurance c. Medicare		
Cost effectiveness of NP/PA		
Malpractice		
Prescribing/ dispensing		
Hospital Privileges for NP/PA, MD		

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Barrier	Description of Problem Created for Team	Team's Solution or Position on Issue
Standardized procedures for NP		
Direct MD supervision of PA		
Physician Oversurplus and GEMANEC Report		
Family Practice physicians' position in the medical hierarchy		
Other		

REFERENCES

1 Merry, Uri; Allerhand, Melvin E.: Developing Teams and Organizations, Addison-Wesley Publishing Co., Reading (Mass.), 1977, p. 201-204.

MODULE III

Team Building Skills

Team Building Skills

Accomplishing the task of providing care to a number of patients and being productive and cost effective can be so time consuming that the NP/PA-MD team members may never feel free to stop and evaluate if what they are doing is what they should be doing or want to be doing, if they are doing it well, or if they could improve care by doing something different. Individuals within the team may be dissatisfied with their roles. Decisions may be made hastily, haphazardly, and occasionally autocratically. Problems may be left unattended until they interfer with the team's work. Fortunately, some teams do find their own ways to improve their methods of dealing with issues and each other; they are able to improve teamwork by themselves.

This module contains exercises, readings, and a bibliography to help the NP/PA-MD team develop skills in goal setting, collaborative decision making, problem solving, conflict management, and role negotiation. These skills will help them improve their teamwork and their patient care. This is another area where the experience is more effective when members of the larger support and referral team are included in the group sessions. The support team is more likely to accept staff roles and goals when they share in their development. They also need the process skills covered in this section.

OBJECTIVES

By completing this module, the team will accomplish the following:

- Collaboratively determine how team decisions will be made.
- Jointly establish team goals and procedures for achieving the goals.
- Clarify individual responsibilities and negotiate a satisfactory role within the team.
- Recognize differences and team issues, confront them openly in a constructive manner.
- Use conflict resolution techniques to resolve or manage issues in a way that maximizes personal satisfaction and task accomplishment.

SECTION A: TEAM GOALS

Overview

This section includes one reading and two exercises. The presence of client and organizational representatives and other team members helps the NP/PA-MD team set realistic goals and gain the support of the entire team in accomplishing the goals. Faculty or consultant facilitation is especially important if client and organizational representatives are present.

Readings

1. "Team Purpose and Goals"

Bibliography

Ducanis, Alex J.; Golin, Anne K.: The Interdisciplinary Health Care Team, Aspen Systems Corporation, Germantown, Maryland, 1979, pp 90-95.

Exercises

Exercise 1: Establishing the Team's Main Purpose and Patient and Practice Management Goals

Exercise 2: The Team Working Contract

The variety and pressure of demands on NP/PA-MD teams from their clients, the community, the parent organization, and from each other often keep them so busy that they do not take time to determine what their main purpose (sometimes called mission) and goals are. Thus, they are not evaluating what they are accomplishing or what they wish to accomplish. This reading is to provide the team members with some criteria to help them determine and state their purpose and their patient and practice management goals. It should be read before the team does Exercise 1: "Establishing the Team's Main Purpose and Patient and Practice Management Goals."

TEAM PURPOSE AND GOALS

The team's statement of purpose gives direction to the team's actions. Its goals identify more specifically what the team feels it should be doing. Team goals establish the means for accomplishing and measuring the accomplishments of the statement of purpose. The team's goals are affected by client, organizational, and individual team member's professional goals.[1]

Guidelines for Evaluating Goals and Procedures:

- Goals and procedures need to be clear, specific, and achievable.
- Goals need to reflect the needs of the client, the team, the team members, and the organization.
- Goals focus energy and act as guidelines for what should be. The team members must take care and periodically evaluate their goals to determine that individual goals, e.g., self perpetuation or advocacy of a specific role, have not become their sole goals, thus defeating the purpose of a health care team to improve patient care. Feedback from clients and from the organization can help ensure this.
- Goals may be short term or long term, task or team maintenance.
- Goals serve as plans for action and standards for how well individuals, teams, and organizations are performing.

- Goals are a source of legitimacy for people's actions and decisions.
- Some sense of shared goals is necessary to optimal team function.
- Goal conflict and unverbalized hidden agendas can jeopardize teamwork and patient care.[1-2]

Exercise 1: Establishing the Team's Main Purpose and Patient and Practice Management Goals[3]

Purpose

The exercise will help the NP/PA-MD team determine its main purpose and goals. Because what the NP/PA and MD can accomplish is dependent on other team members, inclusion of these others in the process will help the team develop and carry out realistic goals. The team members must take into consideration the goals of the client population and the organization. Task goals and team maintenance goals should be differentiated.[4]

Time required:

This is a very time consuming and challenging task. It may take a 4-8 hour session or may be completed in a number of sessions.

Instructions

1. Before the session, team members need to read: "Team Goals and Procedures" in the manual and the bibliography selections for Module III, Section A.
2. Consider including client and organizational representatives in the session to integrate their goals into the team's goals and to help them understand the team and its goals. If they are included a skilled facilitator is needed to help everyone benefit from the session.
3. Each team member needs to bring to the session both a written statement of how he or she sees the team's purpose and a list of the goals.

Example of Purpose Statement - Provide comprehensive primary care to patients.

Example of Patient and Practice Goals - Develop patient education materials which emphasize preventive measures and self care.

4. Team members share their statements of the team's main purpose. With comments and feedback from the client and organizational representatives, the team develops its statement of main purpose.

5. The team shares lists of patient and practice management goals. Together with visiting representatives, they brainstorm to add any other goals and compile a list of all possible team goals.

6. They discuss and critique the goals as a group, discarding those they feel are inappropriate and combining similar goals.

7. The team develops its list of goals. These goals will be finalized and their priority established in Exercise II.

Adapted from Rubin, Plovnick, and Fry (3).

Exercise 2: The Team Working Contract[5]

Purpose

The purpose of the exercise is for the team to prioritize goals and develop a working contract. This helps the team organize its work. Goals can be identified as long term or short term goals. The working contract will consist of the team's statement of purpose and patient and practice management goals. The team members can evaluate their accomplishments periodically by evaluating how they are living up to their contract.

Time required: This exercise may be included with Exercise I in a whole day workshop or it can be conducted as a separate session. It will take approximately 3 hours for this exercise.

Instructions

1. The facilitator defines the purpose of the session and the process to be used. An objective faculty member or consultant facilitator is needed to help the team conduct the session effectively and incorporate concerns and perspectives of the support team, clients and organizational representatives.

2. The list of patient and practice management goals that were developed in Exercise I is put on a blackboard or on paper for all to see.

3. The team discusses each goal to determine if it helps accomplish the purpose, is realistic and clear, and is something the team members agree they should do.

4. When they have obtained a mutually agreed upon list of goals, the team members review the list again to prioritize the goals (High Priority, Moderate Priority, and Low Priority). Final goals will no doubt reflect the concerns of organizational and client representives and support staff participating in the sessions.

5. The team incorporates its statement of purpose and goals into a written working contract.

6. Team members agree to implement and sign the contract with the understanding that it is a working document subject to review and change by the team as circumstances warrant.

7. Arrangements are made for each team member and any other relevant groups to receive copies of the team's written contract.

Adapted from Rubin, Plovnick, Fry(5)

Section B: Decision Making and Problem Solving

Overview

This section contains four readings and four exercises. The readings and exercises indicates which readings should have been completed before the session.

Readings

1. "Decision Making"
2. "Identification of Types of Problems"
3. "Problem Solving"
4. "Rules for Brainstorming"

Bibliography

Easton, Allen: *Decision Making, A Short Course for Professionals*, John Wiley and Sons, New York, 1978.

Gordon, Thomas: *Leader Effectiveness Training*, Bantam Books, Inc., New York, 1978, pp 205-213.

Exercises

Exercise 1: Analysis of Present Decision Making Methods and Plans for the Future

Exercise 2: Problem Identification and Diagnosis

Exercise 3: Brainstorming

Exercise 4: Decision and Implementation

Physicians, nurse practitioners, and physician assistants in the health care delivery system make many decisions alone or with others everyday. How these decisions are made affects the team, the individuals on the team, and the patient; therefore, it is important that the team determine its decision making process. This reading gives the team information about decision making methods and guidelines for improving its decision making process. It should be read before doing Exercise 1: Analysis of Present Decision Making Methods and Plans for the Future.

DECISION MAKING

In determining its decision making process, the questions a team needs to answer include:

- What problems or questions need resolution or action?
- What should be involved in the decision making process?
- What decision making process should be utilized?
- What problems are the team's, which belong to others (e.g., administration) and which belong to everyone in the organization?
- What problems need to be discussed first in the team and then taken to the other groups?
- Who will be responsible for implementation of which decisions?[6]

Analysis of the present decision making structure and the team's satisfaction with it, identification of the various decision making processes, and understanding some of the guidelines for improving decision making will help the team members determine an effective mechanism for themselves.

Guidelines for Improving the Decision Making Process

1. In deciding how to handle decision making and who is responsible for what, one should look at the level of expertise and kind of information needed and the importance of the decision to the people who will be affected by it.

2. As often as possible, a decision should be made by those whom it will affect and by those who will implement it. Those individuals have relevant information that will permit a better decision to be made. They will also have a great impact on implementation.

3. Group participation provides more information on which to base decisions, more creative solutions, and increased cooperation for implementation.

4. Don't burden large groups with decisions that can be made in small groups.

5. Groups may make poor decisions when social pressure leads to conformity, or approval takes precedence over the decision.

6. Recognize that decision making for the individual involves a tolerance of ambiguity, a good self-concept, and risk taking.

7. Clarify problem areas and issues.

8. Clarify the relationship between decision making and action.

9. Be sure that the decision makers have all the necessary information and expertise.

10. Strengthen internal communications.

11. Improve the working relationship at all levels.

12. Improve problem-solving skills.

13. Understand organizational objectives and activities.[7]

Decision Making Methods

Method	Comment
Default decision making	The process occurs when a suggestion is made and because there is no objection, the solution is adopted. This process may be appropriate when the problem is not of great concern to individuals or in an emergency; however, the process can reflect withdrawal, non-participation, non-involvement, and a lack of commitment to implementation of the the decision.
Authorative or hierarchical decisions	This method is very appropriate in time of emergency or when the decision is purely administrative or is of a delicate or specialized nature. In other situations, limiting the membership of the group may cause the decision makers to make a decision with a lack of needed information. Implementation may be nonenthusiastic, at the least, or, worse yet, resisted. In addition, the procedure is not conductive to the maximum development and use of the team's potential.
Minority decisions	At times the team may more efficiently give the responsibility for certain decisions to the expert or experts because of their expertise or to a small group that can decide for all.
Majority decisions "voting"	This is the most frequently used method of decision making in organizations. It is an efficient, formal, precise method. The disadvantage is that it contains an element of winning and losing which may create some resistance to implementation.
Hidden disagreement syndrome	This type of decision making occurs when team members are afraid to voice their basic concerns. Decisions are often made without all the necessary information and without commitment. There is danger that no one may be happy with the decision.

Consensus decision making	In this method, all the individuals involved reach mutual agreement on a plan of action. This does not mean that all team members totally agree with the solution, but that they have had the opportunity to be involved in the process, to share their knowledge about the question, and to come to a decision they can accept. This process can be very time consuming.[8-11]

Team Decision Making

In determining its decision making process, the team must take into account who will be affected by the decision, the level of expertise needed, and the nature of the decision. In areas where the whole team has information and an investment in the decision or where interdependent action is required to get the job done, consensus decision making is desirable. At other times one of the team members may be the expert or the appropriate person to make a given decision. The basis for utilizing this combination of decision making methods is mutual respect.

The NP/PA-MD team members are constantly involved in problem solving with their patients and patients' families; however, the identification of problems within their own team's structure, function, or outcomes, or in the parent organization may be threatening. Physicians who feel ultimately responsible for their patients' care or who feel possessive about their practices may tend to resist problem solving by the team. The nurse practitioner or physician assistant who feels insecure about his or her own competence or position may ignore problems and feel insecure in problem solving.

Problems can be a sign of growth and adaptation. Ignoring them or solving them in authoritarian manner may cause the effectiveness of the team to suffer. Whether the team members are problem solving with their clients, among themselves, or with the organization, the chance of obtaining a solution that will be implemented successfully will be increased by their understanding and utilization of a structured problem identification and problem solving method. These readings give the team some guidelines for identifying and solving problems to use in the exercises and in their practices.

PROBLEM SOLVING STEPS

Step 1: Problem identification is a process of recognizing that there is a need for change. "Something is wrong."

Step 2: Problem diagnosis includes recognizing the history of the problem, the cause, effect, facts, and observations that lead to the recognition of the problem.

- The team members identify what they would like to have occur and compare it with what is happening.
- They identify the clues to why there is a problem. "What are we doing wrong?"

- They look at their organization and their team structure and function systematically to pinpoint the times and the places where the symptoms occur.

- The team reviews any recent changes in the process or environment of the organization and/or in the team itself and relates these changes to the times and places where the symptoms occur.

- The above information is compiled into a state of affairs statement: What is happening? How much is happening? Does it happen all the time?

- A tentative list of "it could be" or "it can't be" hypothesis is prepared by the team in an attempt to explain the causes of the problem.

- The hypotheses are arranged in order of simplicity and the most logical assumption.

- The hypotheses are tested, the simplest first. Those that fail to conform to the facts of the problem are eliminated.

- Hypotheses are modified as new evidence is obtained.

- The team continues the process until a hypotheses that fits all the facts is developed.

- The team devises a test to check the validity of the final hypothesis.

Step 3: The decriptive phase defines the problem including the amount of team resources that are involved; the value and/or social, political, moral or ethical facts involved; and the number of important areas involved.

Step 4: Affected interests are identified and objectives defined:

- Who is or will be affected? Who must be satisfied?

- Who should be involved in decision making?

- What priorities can the team assign to the various interests?

- What is the team trying to accomplish? This includes goals of the individual, of interest groups (client, community), and of the organization and the validity of each of these.

Step 5: The team determines the intensity of the problem and their mutual concern regarding the need for solution.

Step 6: Problems are prioritized.

Step 7: Any additional relevant information is obtained.

Step 8: Creative alternative solutions are identified.

Step 9: Criteria that must be met for the solution to be successful are identified. Criteria include:

- Prescriptive conditions which identify what should be accomplished
- Constraining conditions which identify what should be avoided.

Step 10: The above criteria are used to weigh the proposals:

- Will the proposals meet the need for change?
- Can the proposal be implemented?
- Does the proposal contain severe disadvantages?

Step 11: For each proposal, the team prepares scenarios with as much detail as appropriate to look at what their world would be like if that proposal were implemented and rates them as having certainty, risk, or uncertainty.

Step 12: A choice is made among the alternate proposals.

Step 13: The team develop a detailed plan of implementation including:

- Specific steps to be accomplished
- Required resources
- Emergency measures
- Methods to reduce resistance to implementation
- Individual responsibilities

Step 14: The plan is implemented.

Step 15: A method of and time for evaluation is established.[13,14]

IDENTIFICATION OF TYPES OF PROBLEMS[12]

		Level of Expertise/Information Needed	
		Low	High
The degree of importance to all concerned	Low	Whoever has to make the decision does so.	Relevant expert collects information and makes the decision alone.
	High	People affected by the decision make the decision.	Everyone needs to be involved in the decision making process.

Problems may be simple, with only one aspect, or complex, with many different aspects of importance and subproblems.

RULES FOR BRAINSTORMING

Brainstorming: Generating a quantity of ideas.

1. Get as many varied and different ideas as possible.
2. Suspend judgment - don't belittle anyone's ideas and don't censor yourself. Separate evaluation of ideas from the production of ideas.
3. Sometimes the unusual and the impractical solve the problem. Think wildly.
4. Stress quantity of ideas, not quality.
5. Think of ideas you have that are triggered by someone else's suggestions.
6. Combine two ideas and see if they produce a new one.[15]

Adapted from Merry and Allerhand(12).

PROBLEM SOLVING EXAMPLE - SCHEDULING PROBLEM

Step 1: Something is wrong - Patients coming to the practice often do not know what to expect, are given appointments with an inappropriate person, and do not have adequate time allotted for problem.

Step 2: Problem Diagnosis:

- The team wants the patient to know what to expect and to obtain appropriate care within an allotted time frame.
- Problem clues are long waiting periods, patient and staff frustration with scheduling. The nurse and the NP/PA disagree about which patients the NP/PA should see. The MD, NP or PA, and the nurse are angry at the receptionist regarding scheduling. The receptionist is angry at the patient for "lying" about the reason for this visit.
- There is recent change of receptionist.
- The team's state of affairs statement identifies a complex problem in which the patient does not know what to expect, and in which inappropriate time and provider are causing confusion and dissatisfaction.
- The problem could be:
    - The receptionist does not know how to schedule for these providers.
    - The patient changes his or her reason for the visit between calling and arriving at office.
    - The nurse switches the patient's provider and causes a time problem.
    - The provider may not be prepared to see this type of patient.

  It can't be - sabotage from the office across the street.

Step 3: The hypotheses is that the receptionist does not have clear concept of appropriate scheduling procedure for the office. The patients do sometimes change the reason for the visit. The nurse does make some changes in the schedule according to her opinion of who should see the patient. The provider may not always be prepared for certain types of patients.

Step 4: The definition of the problem is that scheduling patients for inappropriate amounts of time or for the wrong provider is causing frustration and dissatisfaction for the patient and the staff and wasting time, energy, and emotion. The problem negatively affects chances of the patient's return to the office, the care he obtains, and the staff's job satisfaction.

Step 5: Everyone is affected and concerned. The receptionist, nurse, and providers must all be involved in decision making. Feedback from patients would be helpful.

Step 6: The team's priority is appropriate patient care and patient satisfaction; therefore, patient dissatisfaction is the problem with the highest priority.

Step 7: Other relevant information obtained is that the receptionist feels that patients who pay cash should see the physician and those with third party payments should be seen by whomever has time.

Step 8: Alternative solutions identified by the team:

- Develop protocol for appointment scheduling.
- Identify which patients M.D. and NP/PA prefer to see and can best serve.
- Nurse will decide who patient will see when patient comes in.
- NP/PA will only see women and minor problems.
- MD will not see any family planning patients.
- Patient will be given choice of provider on phone.
- NP/PA will obtain additional skills.
- Patient will be given explanation of practice on phone.

Step 9: The solution must result in optimal patient care and satisfaction.

Step 10: Weighing the proposals:

- Developing a protocol would help meet a need and can be done. The disadvantage is it would probably be impossible to list every possible type of appointment request.
- Deciding which patients the NP/PA and the MD can see would help and can be done to some extent. It would be impossible to list all possibilities.
- Having the nurse decide which provider should see the patient would sometimes be helpful, if the patient would definitely benefit from seeing another provider or if patient's reason for the visit differs from that stated at the time of the appointment. Most of the time, this is impractical.
- The NP/PA would not see certain types of patients.
- The MD would not see family planning patients. This might not always be possible and the MD may wish to see some types of family planning patients to keep up the skill required, such as IUD insertions.
- Giving the patients the choice would help and can be done; however, the patient may not always be able to make the best choice.
- The NP/PA's training in additional areas might help and can be done. This might take time away from other duties and slow down the practice during the training, but can be an advantage when proficienty is attained.
- Explaining the practice to the patient would help but might be difficult to explain on the phone.

Step 11: Possible outcome of scenarios:

- Protocol provides the receptionist guidelines so she will feel better about her work.
- Receptionist feels that protocol means she is not capable of making decisions, so she refuses to make any decision not specifically stated on protocol. (Scenarios should be developed for all proposals.)

Step 12: A decision is made.

Step 13: The plan for implementation includes the staff developing scheduling protocol together, encouraging the receptionist to use protocol guidelines. The protocol should include the amount of time needed for new patient appointments, for routine and special procedures, and for special types of problems as well as identification of which patients should see which provider and when.

The nurse is given responsibility for patient flow and determination of patient-provider appropriateness according to the protocol for regular visits in unidentified emergencies. The patient is given an explanation as to how the office works and is given choices within the protocols at the time of the appointment. The staff develops written information for the patients regarding appointments for acute problems, specific problems, emergencies, and explaining the role and relationship of NP/PA and MD in the office.

The providers continually evaluate each other's charts to determine quality of care, areas of need for education, and areas where a different provider may be more expedient for patient care. The staff obtains feedback from patients regarding their satisfaction.

Step 14: The plan is implemented.

Step 15: The team plans to evaluate the system by giving patients a satisfaction checklist at time of visit and encouraging them to fill it out and place in a box in the waiting room. The team evaluates their plan at a team meeting in six weeks.

Exercise 1: Analysis of Present Decision Making Methods and Plans for the Future

Purpose

The nurse practitioner, physician assistant, and physician as well as other team members have been socialized regarding their roles in making decisions. This exercise will help them evaluate their present decision making processes in terms of effectiveness, efficiency, and satisfaction, and will help them decide on any changes needed.

Time required: 1 1/2 hours.

Instructions

1. Faculty or consultant facilitation is needed to help the team deal with decision making in a manner that is open, confrontive, and constructive.

2. Since members of the team other than the MD, PA or PA will be affected by the decision and can help or hinder the implementation of the decisions, they should also be involved in the session if possible.

3. Before the session the participants need to read: the "Decision Making" reading in the manual; Gordon: Leader Effectiveness Training, pp 205-213; and Easton: Decision Making A Short Course for Professions.

4. During the session, the group, discusses each question on the decision list to determine how the decision regarding the issue is presently made, who makes it, and whether this is the most effective method, whether they wish to change the method what method they would wish to use.

5. Problem areas can be recorded and dealt with later in problem solving or conflict management sessions if necessary. Resolution of problems should not be attempted here.

NP/PA-MD Team Decision Worksheet

Issue	Present Decision Making Method	Who Decides	Satisfactory		Decision Method Desired
			Yes	No	
What services are offered by the practice?					
Who sees which patients?					
How does the physician spend his or her time?					
How does the NP/PA spend his or her time?					
When is the patient to see the physician?					
When is the patient referred to a specialist?					
How much time is spent with each patient?					
What hours is the practice open?					
What materials are used for patient education?					
When are meetings held? How often? When?					
Who attends meetings?					

Issue	Present Decision Making Method	Who Decides	Satisfactory		Decision Method Desire
			Yes	No	
Content and format of protocols or standardized procedures?					
Income and benefits of team members?					
Limitation of NP/PA activity?					
Addition of new team member? Interviewing? Hiring?					
How are changes made?					
Other					

Problems identified:

Exercise 2: Problem Identification and Diagnosis[16]

Purpose

The purpose of the exercise is to identify the most significant and most disruptive clinical or structural team problems. The exercise gives the team guided experience in problem identification, priority setting, diagnosis, and identification of who should be involved in the problem solving process and in obtaining relevant information to enhance the process.

Time required - Approximately 1 hour. (Exercises 2, 3, and 4 in this section could also be completed at the same time in a half-day workshop.)

Instructions:

1. Prior to the session team members individually:
   - read Identification of Types of Problems, Problem Solving Steps, and the Problem Solving Example in the manual.
   - identify the most significant and most disruptive problem he or she feels is occurring in the team
   - write definitions of the problems and bring them to the session.
2. At the beginning of the session, the facilitator collects all the problems and writes them on a blackboard or large paper so everyone can see them.
3. The team with the facilitator's assistance prioritizes the problems by consensus.
4. Using the problem solving steps and the information about the problem available at the time, the team members diagnose and define the highest priority problem, identify who is affected by it, and clarify their mutual concerns about it.
5. The problem's definition, who should be involved in the problem solving process, and how they should be involved are recorded on the decision chart.
6. The team may decide if all feel resolution has been attained or, if not, team members may be assigned to obtain additional information for further definition of the problem for the next session on brainstorming, which is a continuation of the problem solving process.

Exercise 3: Brainstorming[17]

Purpose

The purpose of this exercise is for the team members to experience how successful they can be in resolving their problems by brainstorming to find a creative solution to their problems.

Time required: 1 hour.

Instructions:

1. Prior to the session, the team members should re-read the rules for brainstorming.
2. The facilitator writes the problem as identified, defined, and diagnosed in Example 2, on large paper, for all to see.
3. Team members supply any additional information that they have obtained about the problem that will help clarify it.
4. This information is then used by the team to write their final definition of the problem.
5. Next, each team member writes down as many solutions or partial solutions to the defined problem as he or she can identify.
6. The solutions are collected by the facilitator, read aloud, and recorded for all to see. No criticisms or comments are allowed at this time.
7. The team is encouraged to share any ideas triggered by solutions offered by others and/or to combine suggestions to create other solutions. These are also recorded.
8. The facilitator sees that all team members receive a complete list of the proposed solutions from the session to allow them to review the proposals before the next session.

Adapted from Merry and Allerhand(17).

Exercise

Exercise 4: Decision and Implementation[18]

Purpose

This exercise is to provide the team with experience in developing criteria to weigh their proposals, in using the criteria to make decisions on the problem solutions, and in developing plans for implementation and follow-up evaluation.

Time required: 2 hours.

Instructions:

1. Prior to the session, each team member develops criteria to evaluate the proposed solutions. Criteria should:

   - help the team meet its goals,
   - be possible for the team to accomplish,
   - not limit the team's initiative, and
   - not make the situation worse.

   Team members also review the proposals and form and record their opinions of the proposals. The criteria and written opinions are brought to the session.

2. Team members share their criteria statements and develop the final criteria they will use to evaluate the proposals.

3. The proposed solutions are written again for all to see.

4. Team members may share their opinions of the proposals in the group or the facilitator can collect written opinions and write them next to the proposals.

5. Using their criteria and the information supplied by their written opinions, the team members evaluate each proposal separately. Portions of proposals that help the team resolve the problem and meet their goals may be combined to create an acceptable solution.

6. After the team agrees on a solution, a plan for implementation should be developed including:

   - specific steps to be accomplished
   - resources required
   - methods to reduce resistance to implementation,
   - provisions for emergencies

7. The team should plan how and when they will re-evaluate to determine how the solution is working.

Adapted from Merry and Allerhand(18).

SECTION C: ROLE NEGOTIATION AND CONFLICT MANAGEMENT

Overview

This section contains three readings and four exercises. The exercise instructions indicate which readings and bibliography selections should be read prior to each exercise. Exercise 2: "Role Negotiation" and Exercise 3: "Conflict Resolution" are similar in that they both provide experience in negotiation and conflict management; however, the focus of the two exercises is different.

Readings

1. "Assertive Behavior"
2. "Role Conflict"
3. "Conflict Resolution"

Bibliography

Brill, Namoi Isgrig: Teamwork: Working Together in the Human Services, J. B. Lippincott Co., Philadelphia, 1976, pp. 72-75.

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Levinson, Daniel: "Roles, Tasks, and Practitioners," The New England Journal of Medicine, 296 (22): 1291-1293.

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Exercises:

Exercise 1: "How Does It Feel?"
Exercise 2: "Role Negotiation"
Exercise 3: "Conflict Resolution"
Exercise 4: "Patient Management Negotiation"

The characteristics of assertive, aggressive, and acquiescent behavior are presented in the reading to help team members identify their present behavior, recognize their reactions to the various types of behaviors, and learn new behaviors. Team members should use this information when doing Exercise 1: "How Does it Feel?"

ASSERTIVE BEHAVIOR

Assertive behavior is an asset to role negotiation and conflict management. Confrontation, one of the effective methods of resolving conflict within the team, is actually assertive problem solving which focuses on issues rather than on the individual.[19]

Listed below are characteristics of a person using assertive behavior:

- goal directed,
- manner clear, consistent, and responsible,
- owns up to strengths and limitations,
- takes compliments and admits errors,
- negotiates issues fairly,
- defends own rights as a person without violating the rights of others or being unduly anxious or fearful regarding the consequence of one's behavior, and
- enhances self respect through stating and acting on own goals clearly and consistently, thus reducing the need to control or manipulate others.

An assertive person uses clear, concise statements, sticks to the issues or problems, expresses thoughts and opinions, shares feelings directly, initiates and maintains conversations, uses "I" or the collaborative "we" messages, and speaks in a loud, firm voice. Non-verbal behavior includes good eye contact, appropriate facial expressions, gestures that enhance spoken words, and body posture that conveys openness and interest.

Assertive people approach conflict situations with a plan. They determine the rights and resonsibilities of those involved and the short and long-term consequences. They express how they feel and think, but listen to others and respect their points of view.

Aggressive behavior produces defensive, hostile responses and may cause more conflict rather than helping to solve the problem. Characteristics of a person exhibiting aggressive behavior are as follows:

- controls or manipulates others,
- expresses feelings and opinions in a punishing, threatening, assaultive, demanding, or hostile manner,
- assumes little responsibility for the consequences of his or her own actions,
- employs verbal assaults, name calling, threats, humiliation, hostile remarks, or guilt-inducing comments to intimidate others, and gives blaming messages.

Acquiescent behavior, by avoiding conflict, often perpetuates a problem. A person demonstrating acquiescent behavior:

- allows others to define oneself and one's rights
- takes the line of least resistance,
- is defensive, guilty, and fearful,
- fears confrontation and conflict,
- "smooths things over" before examining the issues involved, and
- turns to others for answers.

Identifying potentially destructive agressive and acquiescent behavior and changing it, as well as practicing assertive behavior, will help teams minimize conflict.

If conflict occurs, assertive behavior will aid the team in its negotiations.[20,21]

Even though the NP/PA-MD team has discussed roles and developed role descriptions in an earlier section, team members may find that conflicts still occur. Role conflict can cause anger, frustration, misunderstanding, dissatisfaction, limitation of team function, problems with coordination, and, ultimately, problems for the patient seeking care from the team. This reading identifies some of the reasons for role conflict. Understanding these may help the team as they negotiate their role conflicts in Exercises 1 and 2 of this section.

ROLE CONFLICT

The NP/PA-MD team can experience role conflict due to role ambiguity, role overlap, or role overload.[22]

Role ambiguity occurs when organizational, professional, team member, or personal role expectations, policies, objectives, or definitions of scope of practice are unclear. Roles that are new or changing, those that require coordination between departments, and those that are interdependent tend tc be ambiguous.[23] Health care provider roles within a team fit this description.

The following example shows how role ambiguity can occur. The medical director of a clinic hires a nurse practitioner for a position in the clinic. He tells her that he wants to hire her because of her nurse practitioner skills, but does not want her to do too much because his physician colleagues are not in favor of having a nurse practitioner evaluate patients. It is his contention that this approach will allow the physicians first to develop trust in her so she may eventually be able to begin to act as a nurse practitioner. The nurse practitioner, given this admonishment, is unsure of how much information she should gather when interviewing a patient and obtains less information than she would have before her nurse practitioner training. The physicians feel justified in not wanting a nurse practitioner evaluating patients as the data collected by the nurse practitioner is incomplete. The nurse practitioner is dissatisfied and quits the job. Her self-esteem has been damaged, however, and she has difficulty selling herself when looking for a new position. The patients are deprived of the benefits of NP/PA-MD team care. Role ambiguity can cause stress for the individual and the team and less satisfactory care for the patient.

Role overlap can also cause role conflict. The NP/PA-MD team relationship is one of role overlap. The NP/PA is taking on activities that once belonged to the realm of the physician, for example, physical assessment, diagnosis, and treatment. The physician, attempting to provide holistic health care, meet new consumer demands, and gain more self-satisfaction, may be taking on more caring, counseling, and educational activities than before.

Role overlap causes conflict when one team member has negative feelings about other team members performing a particular function that he or she claims as personal territory and thus attempts to bar others from performing that function.[24]

For example, both the physician assistant and the physician may be skilled in suturing lacerations and like to do this procedure. In a practice where there are limited opportunities to suture, conflict due to role overlap can occur if the physician decides that only a physician should suture because it is minor surgery. The patients may be given the impression that the physician assistant barred from the actiivity is incompetent in that area and so may resist being cared for by him or her when necessary. Resentment, anger, and resistance can result within the team.

Role overload occurs when one or more team members have more work than they can accomplish.[25] This may result from a large, busy practice, poor scheduling, a desire to please the patients or the team, or unrealistic expectations due to high standards or idealism. Individuals attempt to work harder, longer, faster, or to do several things at the same time. This can cause a depletion of energy, frustration for other team members, and eventually a decrease in quality of care for the patient. If the entire team is overloaded, they must agree as a team on ways to decrease the workload in order to prevent a decrease that affects only some and not all. If only one individual is overloaded, that individual may compromise the team's productivity, may make the rest of the team feel guilty and resentful, and may personally feel guilty and resentful because of being unable to do all the work well.

Prevention of role conflict requires that the team members understand each other's roles and expectations, respect each other and allow each other to function, and deal with differences of opinion regarding role as quickly and honestly as possible. Role negotiation is a process of evaluating the conflict and resolving differences by compromise.[26] It should not be a win-lose situation but one in which the team and the patient are assured that the result will be such such that they will obtain the full role potential of each team member.

Conflict within the NP/PA-MD team as in any team or relationship is inevitable. The fact that it exists is not necessarily negative; it can signify growth and creativity. The goal, therefore, in dealing with team conflict is not elimination but resolution.

CONFLICT RESOLUTION

Conflict is viewed by many people as destructive, violent, and irrational. However, conflict can be translated into opportunity for change and growth. Conflict can cause the team to find solutions to problems that seem unsolvable. Total absence of conflict probably equals a lack of change. Thus the goal in dealing with team conflict should be resolution by compromise and collaboration which strengthens the team rather than elimination which can cause the team to stagnate.[27]

In order to resolve the conflict the team must determine:

- what is the conflict
- who is having the conflict
- what is causing the conflict
- what are the ways the conflict can be resolved
- the plan for resolution, and
- their follow-up plan.[28]

The conflict may be between team members or between the team and other groups, for example, the team and administration may differ on the importance of taking time out from seeing patients to have team meetings.

Causes of conflict within the team may be due to different and incompatible goals, different ways of doing things, different values, overlapping or ambiguous responsibilities, personality differences, lack of information, a struggle over scarce resources, or a real or presumed threat to the identify or rights of one team member by the action or existence of the other.[29,30]

The way the team chooses to deal with the conflict will be influenced by their socialization and their past experiences with attempting to handle conflict.[31] Methods individuals and teams use to handle conflict include avoiding the issue, discussing issues without discussing differences, "power plays," compromise, and confrontation.

Of these, compromise and confrontation are productive methods for team conflict resolution.[32] Compromise may be useful when individual team members goals and values vary greatly from one another. Confrontation is an assertive problem solving method which can allow focus on issues, not on people, and allows open discussion of differences.[33.34]

The plan for conflict resolution should take into account timing, place, priorities, and a follow-up plan.[35]

Analyzing the conflict, learning assertive and conflict resolution skills, developing a systematic plan for resolution of conflict, and follow-up can assist the NP/PA-MD team in making conflict productive rather than destructive.

Exercise 1: How Does It Feel?[22]

Purpose

The exercise is to help the team members identify their reactions to assertive, aggressive, and acquiescent behavior and develop assertive behavior through using a role play and feedback technique.

Time required: - 1 hour.

Instructions

1. Prior to the session, team members read:
    - "Assertive Behavior" and
    - Edmunds: "Assertiveness Skills".
2. Team members pair off.
3. One team member role plays one of the situations from the "Assertiveness Role Playing List," trying to use assertive behavior.
4. The other then gives feedback on his or her reaction to the behavior and ways that the behavior could be improved.
5. Roles are reversed and the process repeated.
6. Each team member role plays at least two different situations.
7. After the role playing, the participants return to the group for a general discussion and evaluation of the experience.

(An alternative is to videotape the role playing and give feedback when reviewing the videotapes.)

Adapted from Clark (22).

Assertive Role Playing List

Situation 1: The physician's approach to the nurse practitioner/physician assistant who constantly interrupts him for consultation while he or she is seeing patients.

Situation 2: The nurse practitioner's or physician assistant's response to the physician's criticism that he or she spends too much time with patients doing useless things like talking.

Situation 3: The nurse practitioner's or physician assistant's response to the physician's request that he or she function as the nurse or medical assistant as well as see patients.

Situation 4: The nurse practioner's, physician assistant's, and physician's responses to the administrator who insists that each see four patients per hour.

Situation 5: The physician's approach to the nurse practitioner or physician assistant who continually fails to consult him or her before referring a patient to a specialist.

Situation 6: The nurse practitioner's or physician assistant's approach to the physician who is consistently late, leaves early, manipulates the agenda, or does not come to team meetings.

Situation 7: The physician's approach to the nurse practitioner or physician assistant who consults with him or her over things the physician feels that the nurse practitioner or physician assistant should be able to handle alone.

Situation 8: The nurse practitioner's or physician assistant's approach to the physician who insists on having a report on every patient before signing a prescription, yet puts off these reports each time the NP/PA approaches with excuses that he or she (the physician) must see a new patient, often one without an emergency problem. Because of this, the NP/PA's patients have to wait.

Situation 9: A female team member's approach to a male team member regarding his negative reaction to women with GYN complaints. She feels he acts as if the patient's problems are not important, are "all in their heads," or are self-caused and thus should be ignored or punished.

Situation 10: Either team member to the other who "dumps" patients who have requests for pain medication, chronic complaints, or multiple problems into the other's schedule because they do not like to handle those situations.

Exercise 2: Role Negotiation[37]

Purpose:

The exercise is to help the team resolve role conflicts through the use of bargaining techniques.

Time required: A minimum of 2 hours.

Instructions:

1. Prior to the session team members:

   - Read the "Role Conflicts" reading in the manual and bibliography selection: Edmunds, Marilyn: "Role Stress of the Nurse Practitioner."
   - Identify other team members' actions or omissions which have frustrated his or her accomplishment of the team goals,
   - Write a message to the other team members stating what the others should do more of, less of, or the same of to help accomplish the task and why the action is needed. Messages should be specific.

Example of Role Message

Specific message: In order for my patients not to have to wait so long (why), I need you to check if I need you before you start each team member. Each message should be separate. a new patients. (what)

Vague message: In order for us to deliver better health care (why), we need to work out a plan about prescriptions. (what)

Each person should write at least one and no more than three messages to each team member. Each message should be separate.

2. Role messages are exchanged one at a time. The message receiver can ask for clarification of the message. The receiver then

replies in writing to the sender accepting the message and agreeing to the change requested, stating what he or she can do if the sender helps, or providing an alternative action that the receiver can do instead of the request.

3. Sender and receiver discuss the proposals until they reach an agreement.

4. If the situation is complex, confusing, or if it has been a source of repeated conflict, participants may find it helpful to write a role contract. This may include a definition of the problem, what each party will do, and when the solution will be reviewed.

EXAMPLE

Role Contract

Problem Definition: The NP/PA's patients have to wait too long because the MD doesn't want to be interrupted while seeing his patients to sign a prescription but immediately goes into a room with a new patient when finished with the previous one. The only way the NP/PA can get the MD's signature or consult is to wait outside the MD's door. This wastes the NP/PA's time.

What physician will do: Check bulletin board where NP/PA will put note, "Need you in Room 2 for signature or for consultation."

NP/PA will do: Put note regarding need on bulletin board. If no note, MD can go on to other patients.

Review solution - One month later.

Note: Each person should send, receive, and negotiate at least one message. Videotaping the session and reviewing it with the facilitator may be helpful.

Exercise 3: Conflict Resolution[38]

Purpose:

The purpose of the exercise is to help the team members develop skills in conflict resolution by providing them with the experience of negotiating an area of conflict within the team with the assistance of a third party.

Time required: 2 hours for the exercise and 1 hour at a later date for follow-up.

Instructions:

1. Prior to the session team members:

    - Read "Conflict Resolution" in the manual and the bibliograpy selections:

      Brill: Teamwork: Working Together in the Human Services, pp 72-79, and Edmunds: "Conflict," The Nurse Practitioner, pp 42-47.

    - Identify the conflict within the team which is most descriptive of the team funtion. The conflict may have been identified as the team worked on previous exercises or may have arisen out of their joint clinical practice.

2. All the individuals involved in or affected by the conflict should be part of the conflict negotiation process. Who this is should be agreed upon by the team with the aid of the faciitator.

3. The team discusses the identified areas of conflict and agree to work on resolving the one they feel is the most desruptive to their joint practice.

4. The facilitator asks each person involved in or affected by the conflict to write four statements about the conflict:

    - The nature of the conflict as he or she sees it,

- A positive feedback list stating what the other person(s) do regarding the conflict that are helpful to him or her,
- A problem feedback list stating what the other person does regarding the conflict that is intolerable to him or her, and
- An empathy list predicting what the other party has on their positive and problem feedback lists.

5. One of the team members presents his statement of conflict to the others who clarify the statement and each repeat it as they heard it. The facilitator helps the team to concentrate on clarifying the statements, not debate them at this point. The process continues until each team member has presented his statement.
6. With the help of the facilitator, the team develops its statement of the conflict.
7. Then team members each present their positive and problem feedback items and share their empathy lists regarding his or her feelings about other team members' involvement in the conflict. The emphasis of the process is to gain an understanding of the other team member's point of view.
8. The facilitator allows team members to clarify any statements but prevents general discussion.
9. The facilitator assists the team members in negotiating the changes they want and in deciding how the team can work together to bring about these changes.
10. The facilitator lists the actions the team has agreed to and the issues that are unresolved.
11. The team decides how they are going to deal with the unresolved issues or agrees to leave them unresolved for the time being.
12. A follow-up session to evaluate the outcome is planned.

Exercise 4: Patient Management Negotiation

Purpose:

This exercise provides a method for the NP/PA-MD team to discuss and obtain agreement on the nurse practitioner or physician assistant's role in specific patient management situations.

Time required: 2 hours.

Instructions:

1. Prior to the session the team members each read the "Role Negotiation List" and check what the nurse practitioner or physician assistant should do in managing the patients with each diagnosis.
2. Lists are exchanged.
3. The team discusses each diagnosis until an an agreement is reached.
4. This decision is recorded on a separate list as part of the NP/PA protocol.

Role Negotiation

	ASSESSMENT					INTERVENTION							
COMMON PROBLEMS	Obtain History	Do Physical Exam	Do Diagnostic Tests	Order Diagnostic Tests	Make Diagnosis	Manage Independently	Consult Physician	Refer to Physician	Initiate Plan (Dx or Rx)	Provide Patient Education	Counseling	Prescribe Prescription	Non-Pharmaceutical
Failure to Thrive													
Back Pain													
Bursitis													
Cellulitis													
Prostatitis													
Appendicitis													
Bleeding per Rectum													
Asthma													
Acute Myocardial Infarction													
Phlebitis													
Congestive Heart Failure													
Seizure Disorder													
URI													
Pneumonia													

Role Negotiation

	ASSESSMENT					INTERVENTION							
COMMON PROBLEMS	Obtain History	Do Physical Exam	Do Diagnostic Tests	Order Diagnostic Tests	Make Diagnosis	Manage Independently	Consult Physician	Refer to Physician	Initiate Plan (Dx or Rx)	Provide Patient Education	Counseling	Prescribe Pharmaceutical	Non-Pharmaceutical
Dysmenorrhea													
Symptoms of Climacteric													
Syphillis (+) VDRL													
Secondary Amenorrhea													
Dysfunctional Uterine Bleeding													
Strep Throat													
Obesity													
Family Planning													
Diabetes (Controlled)													
Hypertension													
Iron Deficiency Anemia (3 year old)													
Depressive Neurosis													
Alcohol Abuse													
Impotence, Other Sexual Disorders													

Adapted with permission from the Virginia Study in "Guidelines for FNP Curriculum Planning" edited by Darlene Jelinek, RN, FNP, and Bertold E. Umland, M.D.

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MODULE IV

Team Practice Organization

Team Practice Organization

The NP/PA-MD team practice is affected by the type and quality of the relationship between the physician assistant or nurse practitioner and physician and their relationship with the entire team, the institutional structure within which they practice, and other agencies and groups.

Analyzing these relationships can give the team valuable information for organizing their team practice. In Module I, Exercise 1, the team members examined their practice to determine if members were functioning as a team and if improving teamwork would improve the care provided to their clients. Also in Module I, Section B, Exercise 3, the team explored the organizational structure within which it functioned to determine how it affected the practice. Module II focused on the NP/PA-MD relationship. Module III helped the NP/PA-MD team develop team building skills. Module IV gives attention to other organizational aspects of the practice that affect team work such as legal relationships, office or clinic organization and procedures, and structured team communication and tools for organization and evaluation.

To apply what they have learned and explore ways to organize their practice, the team members must be aware of:

- who they are,
- the possibilities and limitations created by whom they must interact with to accomplish their task,
- the different ways they care for patients and organize their work, and,
- tools that are available to help them.

This module contains a few examples of how nurse practitioners, physician assistants and physicians in California have developed their team practices. These examples are provided to show NP/PA-MD teams what others have already accomplished.

Objective

Participants will:

- completely examine the influence of their present contract and the team's methods of handling the interdependent legal areas such as prescribing, reimbursement, malpractice, hospital privileges, and standardized procedures.
- establish a workable, satisfactory contract and procedures.
- assess present office procedures and plan needed adjustments to ensure optional team efficiency.
- improve the team's written and verbal communication with other team members, patients, staff, the community, and their parent institution.

TEAM PRACTICE ORGANIZATION

Overview

This module consists of one section which contains examples of team practice from NP/PA-MD teams in California and three exercises.

Readings

1. "FNP - MD Partnership" - Vickie McKee
2. "Tips on Negotiating a Contract" - Robin Smith, F.N.P.
3. " PA - MD Employment Contract" - Kevin McCarthy, PA-C
4. "The Westside Family Medical Group" - Sally Harvey, F.N.P.
5. "Office Organization in a Collaborative Practice" - Michael Wong, M.D.

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Exercises

Exercise 1: Negotiation of Legal or Organizational Policy

Exercise 2: Improving Internal and External Team Communication

Exercise 3: Organizing Office Procedures to Increase Team Effectiveness

NP/PA-MD teams can have different kinds of legal relationships: partnerships, corporations, employee-employer, and fellow employees of an institution. The manner in which they work out this issue, the other interdependent legal issues, and their team relationship will influence the success of their teamwork and the degree of their satisfaction. In the following pages some California physicians, physician assistants, and nurse practitioners share their experiences and advice regarding these issues.

FNP-MD PARTNERSHIP

Vickie McKee, FNP, and Leigh Hall, MD, are co-owners of their practice in Tahoe City, California. They share evenly the responsibility of decision making regarding the office. The expenses and profits they accrue are determined by the percentage of the income that they generate. For example, if Vickie brings in 34% of the gross income for the month (which is her average) she will receive 34% of the income and pay 34% of the expenses.

Vickie and Leigh recommend that teams have a formal contract drawn up in consultation with a lawyer as protection for both team members. Their present contract covers start-up funds, medical coverage, back-up for Vickie in Leigh's absence, and provisions for handling prolonged illness, vacations, leaves of absence, and termination of association.

Vickie feels the contractual relationship gives her "more credibility within the medical community, a greater sense of responsibility for the practice as well as for patient care, and an ability to provide continuity of care as the partnership allows either partner to be available to their patients at all times. The disadvantage for her is that being part owner of the practice makes termination of her position harder. She sees the satisfaction that Leigh gains from the relationship as the benefit of having two different approaches available to his patients ("the MD and RN approach"), the sharing of expenses, and the availability of coverage for the practice when he wishes to take time off. The last two, she states, Leigh could obtain by being in a partnership with another physician. The dissatisfaction she feels that Leigh has with their relationship is his not being able to share calls in the same manner he could with another physician.

Vickie and Leigh give patients a choice of whom they wish to see but prefer to share patients and have the patients get to know both of them. Their collaboration is shown by Vickie's statement, "We refer to each other easily and frequently. When medical/legal issues arise, Leigh, as the physician, has the final say. Otherwise, we can disagree on methods of health care without ego involvement."

Vickie generally consults with Leigh about patients with unusual problems or those that she needs to refer to him for care, for instance, patients that need hospitalization. Leigh consults with her about patients he would like her to follow in his absence; people he feels would relate to her with more ease, for example, adolescent females; and clients with chronic disease who need patient education and stabilization.

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TIPS ON NEGOTIATING A CONTRACT

Robin Smith, FNP, works with two physicians. He works from 9 a.m. to 1 p.m. (M-F) in association with one of the physicians in a satellite office in Ferndale where he sees over 90% of the patients of the practice referring the others to the physician. From 2 to 6 p.m. (M-F) he works in the other physician's office in Fortuna. He does house calls, has hospital admitting privileges and ER privileges and is negotiating for hospital round privileges at the local acute care hospital. His contract with each physician provides for an hourly wage plus a percentage of the gross billing over $40,400 per annum. (He predicts that the billing for his patients will gross over $60,000 per annum for each physician this year.) Each contract also provides for 3 weeks' vacation, 12 days' sick leave (4 days of which can be no fault leave), 5 days' education leave, and a $250 educational stipend. Robin states that it is very important that a nurse practitioner or physician assistant know what he or she wants for a salary and benefits before negotiation. He recommends that the first contract between the physician and the nurse practitioner or physician assistant be for one year only and that the NP or PA be willing to work for a moderate salary at first without the percentage basis. After two years, however, he feels it is essential to negotiate a percentage figure into the contract; otherwise, he says, "the NP or PA will be working for a wage while producing a very large profit for the MD". The contract should include an agreement that the mid-level practitioner will have access to his or her gross billing figure.

Robin offers some tips to NPs and PAs entering into collegial relationships with physicians:

(1) Be carefully prepared to sell both yourself and your profession. Most MDs have no idea who or what we are except as some kind of vague threat to them professionally. Almost none of them are aware of the economic benefit to themselves of a MD-NP/PA team practice.

(2) Key selling points are these:
   (a) When a physician hires an NP or PA he or she avoids bringing another physician into the practice and into the area. The second physician is always a potential competitor, whether or not he or she breaks away from the practice.

(b) A NP or PA sees patients for the physician, thus patients remain as part of the physician's practice.

(c) The NP or PA can provide coverage of a practice on the physician's day off, on long weekends, and during vacations, thus keeping the physician's patients in the practice.

(d) The NP or PA can generate a great deal of income for the practice, i.e., for the physician, that does not have to be shared with another physician.

From a letter to the author of this manual from Robin Smith, FNP, President of the Humboldt Society of Mid-level Practitioners. Reprinted with permission.

PA-MD EMPLOYMENT CONTRACT

WHEREAS, I, ________________ (hereinafter referred to as Employee), hereby contract and agree to work for ____________ ________ M.D., (hereinafter referred to as Employer), and Employer does hereby contract and agree to employ Employee, we do hereby agree to the following:

1. Employee agrees to perform with due diligence all orders and duties assigned to him from ____________________ M.D., or a backup physician acting in his stead. Employee is not to accept orders from other office personnel.

2. Employer agrees to pay Employee a salary of $__________ per month. Said salary shall be increased once a year by a percentage equal to the Consumer Price Index cost of living increase, or according to mutual agreement.

3. Employer agrees that Employee shall receive two weeks (ten working days) paid vacation each full year of employement. The dates of said vacation shall be set by mutual agreement.

4. Employer agrees that Employee shall be entitled to one-half of a day paid sick leave for each full month of employment. Such paid sick leave shall accumulate to a maximum of ten working days and shall carry over from year to year as long as employment shall continue. It is agreed that such paid sick leave shall be paid only for bona fide sickness and shall not be used for vacation nor have any cash value on termination of employment.

5. Employer agrees that Employee shall be entitled to a maximum of five working days paid leave for actual attendance at medical conference, the dates of which shall be set by mutual agreement.

6. Employee agrees that any time off, other than that described above, shall be without pay and shall only be by mutual agreement with Employer.

7. Employee may participate in Employer's profit sharing and retirement plans or not as he chooses.

8. Employer agrees that in case of death or disability of Employer requiring termination of employment, Employee shall receive one month's salary as relocation pay and employment shall be terminated.

9. It is agreed that at the end of six months from the date hereof Employee shall be evaluated by Employer. If Employee has not met Employer's reasonable expectations, Employer shall give Employee two week's notice and thereafter employment shall be terminated. It is agreed that a like evaluation shall be made at the end of each succeeding twelve months thereafter.

10. It is agreed that this employment contract may be terminated by either Employer or Employee for any reason after giving thirty day's written notice to the other.

WITNESS our hands this ______day of __________, 19___

________________________ ________________________, M.D.
Name Name

* An actual contract negotiated by Kevin J. McCarthy, PAC, reprinted with his permission.

The manner in which NP/PA-MD teams apply the team concept and organize their practice is very individual and personal. Sally Harvey and Dr. Wong provide examples of this in their descriptions of how their team practices operate. The description of the Westside Family Medical Group below is taken directly from Sally Harvey's letter to the author of the manual. It was left as written in order to not destroy the essence of the description of the practice.

OFFICE ORGANIZATION IN A COLLABORATIVE PRACTICE

Practice Goals

The goals of a collaborative (team) practice are the delivery of quality care and the communication of that delivery to the partners.

Relationship to the Public and Professional Community

Both nurse and physician should view themselves as agents of change since they will be communicating their complementary roles to patients, the general public, and colleagues. In an established practice, this has been done by the use of an introductory letter given to all new patients, as well as to old patients that were not familiar with this arrangement.

In order to acquaint and orient their professional colleagues with this collaborative practice, journal articles describing the collaborative effort are published and lectures delivered both locally and nationally (i.e. American Heart Association Annual Convention, 1980, and the American College of Physicians Annual Convention, 1981).

Quality Assurance

Quality assurance is maintained by the high standards expected by the nurse and the physician. Both teach at the post-graduate level, take continuing education courses, and lecture in the community. Both receive journals pertinent to their specialties. A future possibility for quality assurance may be peer-review.

All office personnel are familiar with the collaborative practice philosophy. They are sensitive to the needs of the patients and to the effort needed to facilitate open communication among the patient, nurse, and physician.

Methods

All new patients are seen initially by the nurse who spends from one to two hours taking a comprehensive history and performing a physical examination. She then presents the important positive and negative points of the history and physical findings to the physician in the presence of the patient. The patient has an opportunity to elaborate on any points in the history. The physician confirms the history and the physical findings. He then makes an initial diagnosis and recommends diagnostic tests and appropriate treatment. The nurse explains the tests and clarifies any questions and implications of diagnosis, interventions, and therapy.

Follow-up patients are handled in two ways. For patients that the nurse is assigned, the nurse sees the patient first, and the physician then reviews the disposition with the patient and nurse together. The physician usually sees his assigned follow-up patients alone and discusses the patient and his disposition with the nurse later that day.

The nurse may separately schedule patients for individual or group counselling, teaching, etc., once the new patient is evaluated and as the needs of other patients change.

Each nurse and physician has his or her own message book for phone calls from patients. The nurse and physician take care of these messages themselves or refer them as appropriate. Each reviews the other's message book to keep current on the patients' needs. Verbal communication also assures relating to the other partner which patients were spoken to, for what complaints, and what instructions were given.

Outcome

Caring for patients together is a benefit for the patient and his family since the focus on medical diagnosis and treatment is coupled with focus on the response of the human being in his social milieu. This is particularly advantageous in a busy practice.

NOTE: Dr. Wong says he "used the term 'nurse' rather than 'nurse practitioner' since it is my belief that a qualified nurse, be she a clinical nurse specialist or a nurse practitioner, can fulfill the role in a collaborative practice. As a matter of fact, my new colleague is a clinical nurse specialist in cardiovascular diseases."

"Office Organization in a Collaborative Practice" was written by Michael J. Wong, M.D. The article is dedicated to Shirley St. Amand, R.N., F.N.P., recently deceased, who had been in collaborative practice with Dr. Wong. Dr. Wong presently works with Lora E. Durke, R.N., M.N.

THE WESTSIDE FAMILY MEDICAL GROUP

I think we are an unusual medical practice. Let me first describe our overall philosophy of health. Our view of optimum health is based on the Pali work "aroga" which is one of the Buddha's descriptions of enlightenment. Aroga means complete health, in the highest sense: physically, emotionally, and spiritually. To strive for this extraordinary level of health in our personal lives, we practice the art of meditation, eat a nutritious whole foods-vegetarian diet, exercise regularly, attempt to act and speak with kindness and respect to others, and look upon our medical practice as service to the community. By these steps we hope to embody a new model for medical practitioners and to incorporate the values of "holistic health" into the mainstream of modern medicine.

These are the steps that we try to encourage in our own medical practice for Health Care Maintenance and expecially for those with chronic disease who are looking for self-help management of their illness. With this broad view in mind we try to enrich our relationship with one another including: recreation, exercise, morning and noontime meditation. In this way we have established a deeper relationship with one another and made it possible to cultivate an open, frank communication with one another that allows us to handle problems quickly and effectively--i.e., whatever our individual differences, we never cease to function as a team. I believe that this prevents passive-aggressive behavior and dissatisfaction.

Anyone can call a group meeting to deal with any perceived problem and the group will work together for the solution. We really make an effort to give positive feedback--not just endlessly correcting each other and pointing out faults--and to maintain respect and kindness to each other. Problems get solved faster and easier this way and resentments are less likely to develop. This applies mostly to communication between those working at the desk and the medical staff.

The medical team utilizes noontime for scheduled patient conferences and hallways for impromptu consultations. We have not worked out formal protocols. We treat patients according to our training and updated methods from medical literature and lectures. Since I trained with both these physicians I know their approach to common problems and do not need written protocols. I have, however, found the protocols from the Nurse Practitioner magazine very helpful. We do utilize the general standardized procedure guidelines from the UC Davis FNP program.

A few specifics:

Scheduling: We all see all of our patients. Specific requests either for me or for the doctors are honored as much as possible. Otherwise patients are scheduled for available slots in the time schedule. If one of the providers wants to follow a specific problem (such as a breast lump) he or she will do so, but we have all agreed that a patient should be rotated frequently enough that all of us remain familiar with their progress and condition. I do not do minor surgery, casting, deliveries, etc.

Communication: Among staff members, conferences are scheduled where needed. Between MDs and FNPs, our communication seems to be excellent. We feel secure with our individual skills and manage to complete each other rather than compete with each other. This is probably possible because of our overall philosophy of life and health care.

Our communication with the community is very good, too. Most of us in the office have the advantage of having known or worked with the members of the medical community and part of the local school system for 10-12 years before our office opened. I worked as an aide, then as an RN in the local hospital; Drs. Flinders and Weaver worked as ward clerks and orderlies in local facilities, then as medical students at local doctors' offices before attending their residency programs. Our nutritionist worked on a doctor's elementary school dietary project for several years before receiving his MA and RD and starting nutrition consultation under our auspices. In addition, our doctors serve on the family practice and OB/GYN committees at the local hospital, teach residents at Community Hospital in Santa Rosa, and serve as consultants for Birthright Maternal Outreach Clinic in Petaluma and for the Petaluma chapter of Hospice. I meet with the local NP on a regular basis.

Our group also meets twice a month with a few other professionals to develop patient education programs utilizing diet, exercise and stress reduction (meditation) for self-management approaches to hypertension, and for promoting health in general. We have started teaching this approach to health professionals in a one-day class at Sonoma State University and will be initiating a four week course at Common Health Care in Santa Rosa. We hope this will be a springboard toward long term classes for the clients interested in changing their lifestyle to benefit their health.

From a letter to the author of this manual from Sally Harvey, FNP, Westside Family Medical Group, Petaluma, California. Reprinted with permission.

Exercise 1: Negotiation of Legal or Organizational Policy

Purpose:

The purpose is for the team members to learn how to prepare for negotiation and to negotiate their legal relationships with each other or with the institution in which they work.

Time required: 2 hours

Instructions:

1. Prior to the session, team members decide what item they want to negotiate, for example, a job contract between the physician and the NP/PA, standardized procedures, prescription procedure, a policy regarding NP/PAs obtaining hospital privileges, or a position paper. They may choose all to work on the same topic or to take separate topics.

2. Each team member brings to the session a draft, written proposal to be negotiated with sufficient copies for all.

3. The facilitator distributes the drafts to all members.

4. If all deal with the same topic, the team discusses the areas of apparent agreement in the drafts to determine clarity and agreement. If separate items, all provide feedback and the negotiation proceeds.

5. Areas of disagreement are clarified.

6. The team brainstorms for solutions to the areas of disagreement.

7. The team drafts a mutually acceptable final document.

Exercise 2: Improving Internal and External Team Communications

Purpose:

The purpose of the exercise is to help the team evaluate and improve their methods of communicating with patients regarding medical matters or team practice policies, with each other when consulting or recording medical information or with other health care providers community agencies and the public in general.

Time required: 2 hours

Instructions: Prior to the session,

1. The team chooses one area of communication to evaluate and improve. Alternatively, members could choose separate topics.

2. If the communication is a verbal exchange such as consultation, a referral phone call, or verbal explanation of the team to another health agency, team members role play the exchanges while being videotaped. The team and the facilitator review the videotape and discuss methods of improving the communication process.

3. If the communication is written, such as a medical record, a referral letter, or written description of the team process for the patients, team members bring in drafts of the proposed communication form. The team uses the drafts to develop a form, such as a referral form, a telephone triage form, or a notice to patients, the community, other health care providers or agencies explaining their team practice.

Exercise 3: Organizing Office Procedures to Increase Team Effectiveness

Purpose:

The purpose this exercise is for the team to evaluate office procedures to see how they influence the team's effectiveness and to determine ways to improve these procedures.

Time required: 2 hours

Instructions:

1. Prior to the session, the team decides what area of office procedure or organization they wish to work on, for example, appointments, telephone triage, lab or Xray referrals, patient education or team conferences. Alternatively, each participant may choose a separate topic.

2. With the facilitator they identify what is effective and what is ineffective in their present system or procedure.

3. They then brainstorm to identify potential changes or ways to improve the system or procedure and use the problem solving method from Module III to determine their suggestions for improving the system or procedure, write up their suggestions for a new procedure, and plan a meeting to discuss their proposal with the appropriate individuals.

MODULE V

Health Care Team Maintenance

Health Care Team Maintenance

Teamwork requires a constant dedication to team maintenance and renewal. This can be accomplished by evaluating team and team member performance, team meetings, team goals and the team's meetings, team goals and the team's internal and external relationships.

Taking the time to assess performance of team member's tasks and of team maintenance roles by self analyses and observer feedback can help the individual and the team appreciate each person's contributions, locate potential or actual areas of role conflict and obstructive behavior, and obtain information that may help them improve in individual action or team communication patterns.

Regular, productive team meetings provide time for the team to plan new activities, work out problems, and evaluate progress. Team meetings can become more productive and less frustrating when team members look at what is happening in their meetings and use that information to improve their meetings.

Periodic reassessment of team goals, issues, and internal and external relationships and communication allows the team to evaluate progress, identify problems, and plan for the future.

This module contains exercises to help the team examine these issues. The exercises can be done on a regular basis or when the team feels they would be helpful or are needed.

OBJECTIVES

Participants will:

- re-evaluate the team's composition, structure, administration, internal and external systems, and environment to determine if changes need to be made in order for the team to accomplish its purpose and goals.
- assess the effectiveness of the team meetings.
- develop plans to change ineffective team processes.

HEALTH CARE TEAM MAINTENANCE

Overview:

This module consists of five exercises for team assessment and renewal. It does not contain any required readings. The team can choose to utilize the exercises on a regular basis or when they seem to be needed or appropriate.

Readings:

There are no readings for this module.

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Exercises:

Exercise 1:	Self Analysis of Task and Team Maintenance Roles
Exercise 2:	Observer Feedback
Exercise 3:	Team Meeting Evaluation
Exercise 4:	Team Effectiveness Diagnostic Instrument
Exercise 5:	A Functional Yardstick for Team Analysis

Exercise 1: Self-Analysis of Task and Team Maintenance Roles

Purpose

The purpose of this exercise is for the team members to evaluate periodically the performance of their task and team maintenance roles and to examine the influence this has on the team.

Time required: 1 hour.

Instructions:

1. After a team meeting each team member fills out the self-analysis checklist.

2. When all the team members have completed the check lists they each read aloud their self-analyses.

3. Team members may add their opinions or question their team members' analyses. The facilitator may help this be a more productive exercise by providing a safe, constructive environment. The objective of the sharing and feedback is to have team members identify behavior that is helpful to the team and that which hinders it.

5. The facilitator can help the team identify non-functioning behavior and assist them in changing this behavior in order to increase their effectiveness.

Self-Analysis Checklist

TASK ROLES	WHICH ROLES OR PARTS OF ROLES DID I PLAY TODAY
Initiating activity	
Seeking information	
Seeking opinions	
Giving information	
Giving opinions	
Elaborating	
Coordinating	
Summarizing	
Testing feasibility of proposals	

GROUP MAINTENANCE ROLES	
Encouraging	
Gate keeping	
Standard setting	
Following	
Expressing group feelings	
Relieving tension	

EITHER TASK OR GROUP-MAINTENANCE ROLES	
Evaluating	
Diagnosing	
Testing for consensus	
Mediating	

NON-FUNCTIONAL BEHAVIORS	
Being aggressive	
Blocking	
Self-confessing	
Competing	
Seeking sympathy	
Special pleading	
Horsing around	
Seeking recognition	
Withdrawing	

Exercise 2: Observer Feedback

Purpose

To increase team members' skills in observing the team's behavior, in giving feedback, and to help the team evaluate and improve its behavior as it develops. This exercise is helpful if the team is having difficulty determining the source of frustration in team meetings, if the team wants to improve participation, or if team meetings are not productive.

Time required: 1 hour.

Instructions:

1. Prior to a pre-determined team meeting one of the team members is appointed to be the observer. He or she reads the "Hints to the Observer" to prepare for the meeting.
2. During the meeting the observer records how people are functioning at the meeting.
3. At the end of the meeting, the observer asks the other participants to fill out End-of-Meeting Suggestion Slips and give them back to him or her.
4. After the slips are collected, the observer gives the team feedback on the behavior observed.
5. The information gathered from the team members can be fed back by the observer at the end of the meeting or at the beginning of the next meeting.

USING AN OBSERVER AS A TECHNIQUE FOR TEAM IMPROVEMENT

What does the observer do? He withdraws from active participation in the group so that he can watch the group in action and take notes on what he sees. Whenever the group requests a report, he talks about some of the things he has observed. Why have an observer? The group is stimulated to think about itself and the way it conducts its affairs. It is believed that a group can learn to control its actions and improve itself. The observer holds up a mirror to the group.

Hints to the observer

You will find it very difficult to take down everything that happens. Therefore, do your observing for a while in a single area of observation, such as participation, atmosphere, or leader role. When you gain an understanding in one area, you are ready to move into another. Gradually you will become able to observe many areas at the same time.

What is done is recorded by the secretary, not by you. Your main job is to reflect back to the group how it was done.

One way to observe is to jot down questions. Why was that done? What could have been done there? Why wasn't it? When you give your report, ask these questions, and expect answers.

Reporting back to the group (usually called "Feedback") is as important as the observing itself. Bear in mind that if the group is not ready to hear something, you'd better not say it.

Here are some pointers on your first feedback:

1. You may have noticed some personality clashes, jealousies, hostilities, etc. That's good observing, but you'd better keep such knowledge to yourself for a while.

2. Do not criticize or attack the group. The group is not used to it and will become defensive and angry at you. That will end your usefulness to the group.

3. Introduce many of your comments with something like, "I wondered about..." or "Could it have been done..."

4. Maintain a good relationship with the group. Do no judging. Be supportive.

5. Start with an area of observation that is least personal, such as participation.

AREA OF OBSERVATION: ATMOSPHERE

Do the members feel completely free to express themselves: What is the evidence?

What signs are there of friendliness, unfriendliness, formality, informality?

What signs of co-operativeness are there? Of competition?

Area of observation: Participation

How lopsided is the participation? Why? Are some too eager? Others not eager enough? To what extent do the too-eager try to pull in the others?

Are the comments kept to the topics? Brief? Clear? Factual? Emotional? Do the members listen to one another? Weight the value of what is said? To whom are remarks usually addressed? Were the decisions group decisions? Dictated decisions? Sheep-like decisions?

Area of observation: Goals

How does the group choose its goals?
To what extent does the group understand what it is trying to do?
To what extent does the group understand why it is trying to do it?
Were all equally interested in the goals?
Was interest maintained or did it lag?
Was there any evidence of willingness to subordinate personal interests to the common goals?

How far did the group get?

Area of observation: Inter-action within the group

What are the signs of power structure? Status?
What are the alliances?
What other kinds of sub-groups are there? (Wise-crackers, etc.)
What is the purpose of these sub-groups? How do their members work together? What is the effect on the total group?

What understanding is there of the needs of other members?
How well does the group work as a team?
How does the group act when it faces a serious decision? How do the members re-act to the decisions when made?

Area of observation: Leader role

How aware is the leader of what's in the minds of members?
How does he or she influence group decisions? Deliberately?
What status does the group give him or her?
Is he or she aware of individual needs?
Does he or she become involved emotionally?
What are the evidences that he or she is autocratic? Passive? Democratic?

Area of observation: Member roles

Which members seemed most interested in the way the group was performing? What did they do?

Which members seemed most interested in the specific problem being discussed? What did they do?

Which members seemed most interested in themselves? New? Attention seekers? Monopolists? Non-participants? Distractors? Hair splitters? Disruptors? Debunkers?

USING EVALUATION AS A TECHNIQUE FOR IMPROVEMENT

Many groups use an End-of-Meeting Suggestion Slip, which is filled out by each member and given to the observer. At the following meeting the observer "feeds back" the material according to its usefulness.

End-of-Meeting Suggestion Slip

1. How did you feel about this meeting? Please be frank. (Check on the line)

   No Good   Mediocre   All Right   Good   Excellent

   ____

2. What were the weaknesses?

3. What were the good points?

4. Any suggestions?

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Exercise 3: Team Meeting Evaluation

Purpose

The purpose of the exercise is for the team to evaluate and improve their team meetings.

Time required: 30-45 minutes.

Instructions:

1. After the meeting the team members fill out the form "Meetings."

2. One of the members gathers the sheets and determines and informs the team about the areas of their agreements and disagreements about the meeting.

3. Problem areas are identified and solutions for the problems discussed.

4. Plans for improving the meeting are made and recorded.

5. At the end of the next meeting the plans are reviewed and the meeting evaluated to see if the plan helped improve the meeting.

MEETINGS

Stated below are some events which transpire in team meetings. Each team member is asked to use this to evaluate the team meeting.

Key: Consider what typically happens in this meeting. For each of the items below, enter the number opposite the statement which is most descriptive of the meeting.

6 This is very typical of our meetings; it happens repeatedly.
5 This is fairly typical of our meetings; it happens quite often.
4 This is more typical than not, but it doesn't happen a lot.
3 This is more untypical than typical, though it does happen some.
2 This is quite untypical; it rarely happens.
1 This is not typical at all; it never happens.

_____ 1. When problems come up in the meeting, they are thoroughly explored until everyone understands what the problem is.

_____ 2. People ask why the problem exists, what the causes are.

_____ 3. The group discusses the pros and cons of several alternate solutions to a problem.

_____ 5. The average person in our meeting feels that his ideas have gotten into the discussion.

_____ 5. Someone summarizes progress from time to time.

_____ 6. The group discusses and evaluates how decisions from previous meetings have worked out.

_____ 7. From time to time in the meeting, people openly discuss the feelings and working relationships in the group.

_____ 8. Some very creative solutions come out of this group.

_____ 9. When conflicts over decisions come up, the group does not avoid them, but really stays with the conflict and works it through.

_____10. There are many problems which people are concerned about that never get on the agenda.

_____11. There is a tendency to propose answers without really having thought the problem and its causes through carefully.

_____12. People bring up extraneous or irrelevant matters.

_____13. Decisions are often left vague as to what they are and who will carry them out.

_____14. There is a good deal of jumping from topic to topic. It's often unclear where the group is on the agenda.

_____15. The same problems seem to keep coming up over and over again from meeting to meeting.

_____16. People don't seem to care about the meeting or want to get involved in it.

_____17. There are splits or deadlocks between factions or subgroups.

_____18. The discussion goes on and on without any decision being reached.

_____19. The same few people seem to do most of the talking during the meeting.

_____20. People hesitate to give their own views about the problems discussed.

_____21. Many people remain silent.

_____22. People give their real feelings about what is happening during the meeting.

Meetings vary according to their primary focus of attention. They may be mainly focused on information-giving--making announcements, explaining plans or rules, dealing with routine matters. Or they may be mainly focused on problem-solving -- discussion and decision, working out answers to problems on the spot.

23. Thinking now of the meeting you have been describing, what percentage of time do you estimate is actually spent on these two kinds of activities? Fill in the figures below.

__________% + __________% = 100%
Time spent on information-giving + Time spent on problem-solving

24. Now, still thinking of this meeting, what percentage of time do you think should be or ought to be spent on these two types of activities?

__________% + __________ = 100%
Time spent on information-giving + Time spent on problem-solving

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Thornton, Barbara: Department of Social and Health Resources, University of Nevada, Reno.

Exercise 4: Team Effectiveness Diagnostic Instrument

Purpose

The purpose is to evaluate the progress of the team's development in order to determine what processes the team needs to continue working on.

Time required: 1 hour.

Instructions:

1. Each team member fill out the "Team Effectiveness Diagnostic Instrument" and individual data summary sheets.
2. The facilitator collects the summary sheets and gives the team feedback on their responses.
3. Problem areas are identified and the facilitator helps the team begin to develop a plan to deal with the areas that are hindering the team's effectiveness.

TEAM EFFECTIVENESS DIAGNOSTIC INSTRUMENT

Directions: In the following scales, circle the letter that you think most accurately reflects where your own description of your team would fall between the two descriptive statements provided (I and II). Read both statements before deciding on your response. If your description is more like the top statement (I), then you should circle letter "a" or letter "b". If your description is more like the bottom statement (II), then you should circle "d" or "e". Your answer should represent how you think things acutally are, not how they should be or how you wish they were. These responses will be summarized anonymously and discussed by the team.

In the spaces for examples below each scale, write down a real situation which describes your response on the numerical scales.

Goal Clarity and Conflict

THINGS ABOUT "WHY WE ARE HERE"

Scale 1

Statement I - I often wonder what is the basic reason for being here. It seems to be that there are people on the team (maybe even myself) who spend a lot of time and energy doing things that are not consistent with what I think is our main purpose in being here. They downplay or overlook important parts of our total objective or their time is directed at things I think aren't very important.

a. Just like I

b. More like I than II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - The team's basic overall objectives are very clear to me. All of my and everyone else's effort seems directly related to getting these key goals accomplished. Whenever a question arises over what things need to get done, we are able to set priorities by referring back to our basic objectives.

Example(s): In the space below describe one or more examples of situations in the team that illustrate your response on Scale 1.

Role Ambiguity

"THINGS ABOUT MY JOB"

Scale 2

Statement I - Often situations arise on the job where I'm not certain what I am supposed to do. Frequently, I'm not even sure if a situation is my responsibility or someone else's. We never get together to discuss what each individual thinks he (she) and the others on the job can or should do to work together to do the best job.

(circle one)

a. Just like I

b. More like I than II

c. In between I and II

d. More like II than I

e. Just like II

Statement II - In almost every situation I am very sure about what responsibilities I have and about what others on the job are supposed to be doing. These job responsibilities are often discussed by relevant members of the team, particularly when someone has a question about what he or someone else should be doing.

Example(s):

Role Conflict

Scale 3

Statement I - Different people on the job are always asking me to do different things at the same time. Often these tasks get in the way of each other or there just isn't enough time to meet everyone's demands. My job makes me feel like a juggler with too many balls.

a. Just like I

b. More like I than II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - I have no trouble doing the different things that the job and other people on the team require of me. I understand why I'm supposed to do the things I do and it all seems to fit together. If I feel as though the demands people on the team make of me are getting too heavy or don't make sense, we resolve the problem with a discussion.

Example(s):

Participation/Influence

"HOW THINGS GET DONE AROUND HERE"

Scale 4

Statement I - When some people try to participate in a discussion of job issues they often get cut off or their suggestions seem to die. People seem to pay attention only to some team members and not others. Some people seem to do most of the talking while others don't participate very much.

a. Just like I

b. More like I and II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - Everyone gets a chance to express himself and to influence the group in discussions about the job. We listen to every person's contributions and try to discuss the strong points in each. No one is ignored. Everyone is drawn into the discussion.

Example(s):

Commitment/Understanding

Scale 5

Statement I - When we sit down to discuss something I usually walk away wondering what we just did and what is supposed to happen next. If, as a result of a discussion, I am assigned to do something, I often do not agree with the tasks assigned me. It seems like the same problems keep coming up for discussion even though we thought we had worked them through already.

a. Just like I

b. More like I than II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - When we have a problem to discuss, I usually understand exactly what the issue is. By the end of the discussion, I usually understand what we have decided to do about it, and what my responsibilities are. Decisions made by this team are carried out effectively by the team members.

Example(s):

Conflict Management

"HOW THINGS GET DONE AROUND HERE" (Con't)

Directions: This scale is different from the previous ones. In this scale, read all the statements and circle the letter next to the one statement that most closely describes the general situation in your team.

Scale 6

When a disagreement arises in the team:

a. We assume it's probably best not to let it get personal, we let it pass hoping it will cool down and eventually be forgotten. If it does start to ruffle feelings, we try to smooth the feelings and make the least of the disagreement (e.g. There is really no point in fighting about it, either so, let's forget it," or "We're all grown-ups; we shouldn't argue").

b. Often we end the disagreement when someone on the team either takes charge and makes a decision or decides not to discuss it any further.

c. We try to come to an agreement somewhere between the two disagreeing positions. In other words, we compromise. That way everyone gets a little and everyone gives a little and the disagreement is taken care of.

d. We get the disagreeing parties together and have them talk to each about their points of view until each party can see some logic in the other's ideas. Then we try to come to an agreement that makes sense to everyone.

Example(s):

Recognition/Involvement

"WHAT IT'S LIKE TO WORK AROUND HERE"

Scale 7

Statement I - I often get the feeling that some people on the team don't think that some other people on the team have much of a contribution to make. Some people don't pay much attention to the problems or suggestions of others. People are often taken for granted.

a. Just like I

b. More like I than II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - Everyone recognizes that the job could not be done without the cooperation and contribution of everyone else. Each person, including myself, is treated as an important part of the team. When you bring up an idea or a problem, people sit up and take notice. It makes you feel that you and your job are important.

Example(s):

Support/Cohesiveness

Scale 8

Statement I - This job really gets me down. People do not seem concerned with helping each other get the job done. Everyone is pulling in opposite directions; everyone is out for himself. If you try to do something different, you get jumped on by people for being out of line, or if you make a mistake, you never hear the end of it.

a. Just like I

b. More like I than II

(circle one) c. In between I and II

d. More like II than I

e. Just like II

Statement II - I really like my job, and I like working with this team. The team encourages you to take responsibility. You feel appreciated by the other members of the team when you do a good job. When things aren't going well, people really make an effort to help each other. We really pull together on this team.

Example(s):

Please summarize your responses on this sheet.

INDIVIDUAL DATA SUMMARY SHEET

Scales

1. Goal Clarify and Conflict

I a — b — c — d — e II

2. Role Ambiguity

I a — b — c — d — e II

3. Role Conflict

I a — b — c — d — e II

4. Participation/ Influence

I a — b — c — d — e II

5. Commitment/ Understanding

I a — b — c — d — e II

6. Conflict Management

I a — b — c — d — e II

7. Recognition/ Involvement

I a — b — c — d — e II

8. Support/ Cohesiveness

I a — b — c — d — e II

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Exercise 5: A Functional Yardstick for Team Analysis

Purpose

The purpose is to determine the present status of the team and to update the team's position on their purpose, composition and structure, internal and external system, and other vital issues.

Time Required: The team may choose to discuss one section of the question at every meeting or have a 4 to 8 hour workshop to consider all the questions at one time.

Instructions:

1. This exercise requires a good facilitator to help the team really look at their progress critically.

2. The facilitator helps the team discuss the questions from "A Functional Yardstick for Team Analysis" to determine if there is a need for change in their practice, and if there are problems that need to be addressed.

3. Problems identified are put on the agenda for future problem solving sessions.

A FUNCTIONAL YARDSTICK FOR TEAM ANALYSIS

Each team, like each person, is unique and individual. We can, however, generalize to the extent of pinpointing vital areas in the life space of all teams which determine the success or failure of the teamwork. Each team must know the answers to the questions that arise in these areas, in light of their applicability to its unique self. Each must also be prepared to devote time and energy throughout its life span to keep the answers up-to-date.

Purpose

1. What is the overall purpose of this team?
2. Who defines it?
3. Is there common understanding and agreement regarding its meaning among the various systems and individuals involved?
4. What is required to implement it?
5. What is required to change it?
6. Do the working goals grow naturally out of it?

Composition and Structure

1. Who makes up this team?
2. How is this decided?
3. How are both original and additional members selected and involved?
4. How is membership changed?
5. What provision is made to enable the individual to become a team member?
6. How are the roles of the team members defined?
7. How is the effectiveness of both their uniqueness and their complementarity assessed?
8. How are roles changed?
9. Is there clear and common understanding of team composition and structure among the members?

Internal System

1. What is the underlying value system of this team?
2. How is it integrated with the value systems of the various team members?
3. What are the behavioral norms of this team?
4. How are they arrived at and integrated with the personal norms of the various team members?
5. How do they relate to institutional, community, and societal values and norms?
6. How are they enforced, evaluated and changed?
7. What is the climate of this team?
8. How is it maintained and changed?

9. What are the relationships, personal and professional, among the team members?
10. Where does the power in this team lie?
11. How is it manifested and used?
12. How is it controlled and changed?
13. What are the pressures leading to conformity and groupthink in this team?
14. How are they managed?

Administration and Logistics

1. How is this team administered and managed?
2. What kind of leadership exists?
3. What is the relationship of leadership to administration?
4. How can leadership and administration be controlled and changed?
5. What are the essential logistics of this team's operation?
6. Who provides these supportive and maintenance services?
7. What provisions exist for their ongoing evaluation and change?

Internal Process

1. How does this team communicate within itself?
2. Is there a common language?
3. Is there provision for recognizing and working to clear clogged communication channels?
4. How does this team use discussion?
5. How does this team use conflict?
6. How does this team reach decisions?
7. How do the members of this team collaborate, accept, and implement decisions, both those which they support and those with which they disagree?
8. How does this team use authority?
9. How are individual and team tasks defined and implemented?
10. Does this team consciously use a problem-solving process?
11. How does it deal with breakdowns in this process?
12. How does this team arrange for necessary supervision of itself and its various members?
13. How does this team evaluate itself and its members?

Environment

1. What constitutes this team's environment?
2. What are the relationships involved here?
3. What are the channels of communication?

4. What is happening along the interfaces of the various systems within the environment?
5. What are the linkages between these various systems?
6. How are they used?
7. How are they evaluated and changed?
8. How is this team accountable to those who sanction its work: clients, institution, community, society?

Self-Actualization and Renewal

1. Is this team free and able to evaluate its own work?
2. What provisions does this team make for continuing education of itself and its members?
3. How does this team stimulate, recognize, and use innovation, creativity, and change?
4. Does this team possess the flexibility, in both its parts and its whole, to respond to crisis and change?

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